NATIONAL MEDICAL AID CLAIM FORM

CLAIM NUMBER
DATE-STAMP
DATE-STAMP

MEMBER/PATIENT TO COMPLETE ALL RED SECTIONS

PLEASE INDICATE MEDICAL AID SOCIETY WITH AN "X"

☐ BANKMED ☐ CEMENT ☐ CIMAS ☐ ENG ☐ PUB.SER ☐ MASCA ☐ MUN. BYO. ☐ MUN. HRE. ☐ N'THERN ☐ RAILMED ☐ OTHER - SPECIFY

WHOLE CLAIM COMPUTER INSTRUCTIONS | DELAY P.M | B/P O/R | STAFF

PLEASE PRINT MEMBER'S NAME ______________________________

POSTAL ADDRESS ______________________________

____

CELLPHONE. NO. ______________ EMAIL ADDRESS: ______________

NAME OF EMPLOYER/GOVT. DEPT. ______________________________

IF THIS TREATMENT IS DUE TO AN ACCIDENT, PLEASE PUT "X" IN THE CORRECT BOX BELOW.

☐ ROAD TRAFFIC ACCIDENT

☐ ACCIDENT AT WORK

☐ ACCIDENT AT HOME

☐ OTHER - SPECIFY

PATIENT'S NAME	RELATIONSHIP TO MEMBER	MEMBER'S NUMBER	PATIENT'S SUFFIX No.	PATIENT'S DATE OF BIRTH	B/P O/R	STAFF

SIGNATURE - BEFORE SIGNING, PLEASE NOTE:

1. IF YOU SIGN THIS CLAIM FOR ANY TREATMENT WHICH HAS NOT BEEN PROVIDED YOU MAY WELL BE COMMITTING AN OFFENCE. IF YOU BECOME AWARE THAT THE CLAIM IS SUBMITTED FOR SERVICES WHICH HAVE NOT BEEN PROVIDED YOU MUST CONTACT YOUR MEDICAL AID SOCIETY FORTHWITH.

2. IF THIS TREATMENT HAS NOT BEEN PAID FOR THEN YOU MUST EITHER SIGN EACH DAY THE TREATMENT IS RECEIVED OR ONCE ONLY AFTER THE PROVIDER OF SERVICES HAS INSERTED ALL HIS CHARGES.

N.B. - CLAIM FORMS WHICH ARE SIGNED BEFORE THE DAY ON WHICH THE TREATMENT IS TO BE RECEIVED WILL BE REJECTED.

3. IF THIS TREATMENT HAS BEEN PAID FOR, YOU SHOULD SIGN THE FORM ONCE ONLY BEFORE SENDING IT TO YOUR MEDICAL AID SOCIETY. ATTACH YOUR RECEIPT AND INSERT THE AMOUNT YOU ARE CLAIMING IN THE APPROPRIATE BOX ALONGSIDE YOUR SIGNATURE.

SIGNATURE	DATE	RELATIONSHIP TO MEMBER	FEE CHARGED (IF KNOWN)

I CONFIRM THAT THE DETAILS GIVEN ABOVE ARE CORRECT, THAT THE AMOUNT CLAIMED HEREIN IS NOT CLAIMABLE FROM ANOTHER SOURCE, AND THAT THE PATIENT IS A MEMBER OR DEPENDENT OF THE MEDICAL AID SOCIETY SHOWN ABOVE. I AUTHORISE THE PROVIDER OF SERVICES TO DISCLOSE THE NATURE OF ILLNESS AND TO THE MEDICAL AID SOCIETY FOR ITS CONFIDENTIAL USE, AND I AGREE THAT NO AWARDS WILL BE MADE FOR THIS TREATMENT UNLESS CONTRIBUTIONS ARE RECEIVED IN RESPECT OF THE PERIOD OF TREATMENT.

FOR COMPLETION BY PROVIDER OF SERVICES

NAMAS PAYEE No.	DATE CLAIM CLOSED (DAY / MONTH / YEAR)	ACCOUNT REF. No.

NAME OF REFERRING PRACTITIONER (IF ANY) ______________________________

NAME OF ANAESTHETIST (IF ANY) ______________________________

NAME OF SURGICAL ASSISTANT (IF ANY) ______________________________

FOR USE BY MEDICAL AID SOCIETIES

RELEVANT NAMAS NOS. | B/P O/R | STAFF

LINE.		TARRIF No.	MODS.	QTY.	YR.	MTH.	DAYS.	FEE CHARGED:	AWARD	PERSONAL A.C./ SHORTFALL	REASON	B/P O/R	STAFF
01	M												
02	M												
03	M												
04	M												
05	M												
06	M												
07	M												
08	M												
09	M												
10	M												

GROSS AMOUNT CLAIMED $ ______________

I hereby certify that, I, or members of my staff, have rendered the above services to or on behalf of the patient. I confirm that to the best of my knowledge the patient treated is the patient named on this form. I agree that any claim for services not provided would be regarded as fraudulent and render the person concerned liable to prosecution.

DIAGNOSIS ______________________________