

# GENERATION HEALTH CLAIM FORM



<b>PATIENT OR MEMBER TO COMPLETE SECTIONS IN RED</b>		<b>FOR OFFICE USE ONLY</b>
PRINCIPAL MEMBER'S NAME:		RECEIPT STAMP
POSTAL ADDRESS:		
CONTACT #:	RELATIONSHIP TO MEMBER:	
PATIENT'S NAME:	PATIENT'S MEMBER NUMBER:	
NAME OF EMPLOYER:		
<b>IF THIS TREATMENT IS DUE TO AN ACCIDENT PLEASE PUT AN "X" IN THE CORRECT BOX BELOW</b> ROAD TRAFFIC ACCIDENT <input type="checkbox"/> ACCIDENT AT HOME <input type="checkbox"/> ACCIDENT AT WORK <input type="checkbox"/> OTHER SPECIFY: _____		DOCUMENT NUMBER

**Member or Patient declaration**

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 the fund 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 their charges **NB:** 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 the fund, attach your receipt and insert the amount you are claiming in the appropriate box alongside your signature
4. 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 dependant of Generation Health Medical Fund. I authorise the provider of services to disclose the nature of illness to the medical aid fund for its confidential use, and I agree that no awards will be made for this treatment unless contributions are received in respect of the treatment period

SIGNATURE	DATE	RELATIONSHIP TO MEMBER	FEE CHARGED (IF KNOWN)

**FOR COMPLETION BY PROVIDER OF SERVICES**

AHFoz PAYEE No.  DATE CLAIM CLOSED  DD  MM  YY ACCOUNT REF NO.

NAME OF REFERRING PRACTITIONER (IF ANY): \_\_\_\_\_

NAME OF ANESTHETIST (IF ANY): \_\_\_\_\_

NAME OF SURGICAL ASSISTANT (IF ANY): \_\_\_\_\_

LINE	TARIFF NO.	MODS.	QTY	YEAR	MONTH	DAYS				FEE CHARGED	
01											
02											
03											
04											
05											
06											
07											
08											
09											
10											
<b>GROSS CLAIMED AMOUNT (\$)</b>											

**Diagnosis:** \_\_\_\_\_

**Service provider signature & stamp:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Service provider declaration acknowledged as per signature above:**

Please tick if there are any other matters you wish to bring to the attention of Generation Health Medical Fund and make your comments overleaf

# GENERATION HEALTH CLAIM FORM

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 concerned person liable to persecution

Please tick if there are any other matters you wish to bring to the attention of Generation Health Medical Fund and make your comments overleaf