Generation Health

GENERATION HEALTH CLAIM FORM

Generation Health
P.O. Box 10130
HARARE
Website: www.generationhealth.co.zw

Generation Health
2nd. Floor, Zimnat House
Nelson Mandela Ave./3rd. Street
HARARE

Administered by:
Sovereign Health
Tel: (263 242)793389; 797843; 793476
Nelson Mandela Ave./3rd. Street
Fax: (263 4) 790700
CDMA: (263 242) 2928629; 2928930

PATIENT OR MEMBER TO COMPLETE SECTIONS IN RED		FOR OFFICE USE ONLY
PRINCIPAL MEMBER'S NAME:		
POSTAL ADDRESS:		
CONTACT #:	RELATIONSHIP TO MEMBER:	
PATIENT'S NAME:	PATIENT'S MEMBER NUMBER:	
NAME OF EMPLOYER:		

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

ROAD TRAFFIC ACCIDENT		ACCIDENT AT HOME	
ACCIDENT AT WORK		OTHER SPECIFY: ____________________	

Member or Patient declarationt

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, an I agree that no awards will be mare 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															
							GROSS CLAIMED AMOUNT ($)								

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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**

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