Cedar Healthcare

BENEFIT CLAIM FORM

- This completed form is required in order for the Insurance Company to assess a possible claim.
- Completion of this form by the Insured Member does not in any way limit liability for the Member with regard to any shortfall in expenses occurred.
- Only fully completed claim forms, with accompanying documentation, will be assessed.
- Any cost incurred in the completion of this form will be the responsibility of the Insured Member.

SECTION 1 – GENERAL

Name of Employer:			
Policy Number:		**Date Employed:**	
Full Name of Principal Member:			
Full Name of Claimant:			
Date of Birth:		**Occupation:**	
Postal Address		**Physical Address**	
Postal Code		**Postal Code**	
Contact No. Home	( )	**Contact No. Work**	( )
Cell No.		**Fax No.**	**E-mail**
Name of Medical Scheme:			
Medical Scheme Number:		**Option:**	
Banking Details for Refunds:			
Bank:		**Account Type:**	
Branch:		**Branch Code:**	
Account Name:		**Account Number:**	

Date of Hospitalisation:			
Admission:		Discharge	
Date of Accident:		Time:	
Hospital:			

Give a detailed description of the Hospitalisation/Accident:

Signed:		Date:	

Please attach copies of all accounts received from the Hospital and Doctors. Please note that the account is only valid for the period that you were in Hospital and return to the Cedar Health Member Care Line either by email (**cedarhealth@medicall.co.za**) or fax (**0866 884 996**)

SECTION 2 – FOR OFFICE USE ONLY

Name of Hospital:			
Date of Admission:			
Date Discharged:			
Names of Doctors:		Practice Codes:	
Above Efficient Specialist fee Yes: No:			

Procedure:	Code:	Scheme paid:	Gap Cover benefit @ 300% of tariff: :

		NOTES:	
Gap Cover Benefit			
Paid by Scheme			
Other:			
Total Due:			

Done by:		**Signed:**		**Date:**	
Checked:		**Signed:**		**Date:**	
Cheque No.		**Amount**	R	**Date Paid:**	
Correspondence with Abelard:		R		**Date:**	

Comments:

Client Queries:

File Closed:	