NBCRFLI
Your Road Freight Partner.

Hospital Claims Form

IMPORTANT NOTES AND INSTRUCTIONS:

1. You will be responsible for attaching the detailed accounts as well as the receipts for the payment you have made in respect of the visit.
2. Payments are by Electronic Fund Transfer (EFT) only. Your bank details are thus compulsory in ensuring that you receive the funds due to you.
3. Please keep copies of all documents as well as the proof of submission.
4. Fax or email all the relevant documents to 086 480 6809 or hospitalclaims@nbcrflihealth.co.za
5. Payments are made within 30 days from the date of receipt of the accounts.

This form is required in order for the Insurer to assess a possible claim. Completion of this form by the Eligible Member does not in any way limit liability. Only once we have received a fully completed claim form will we be able to assess the incident being claimed for. Any costs incurred in the completion of this form will be the responsibility of the Eligible Member.

Section 1: Personal Details

Name of Eligible Member:		ID Number:					
Membership Number:							
Full Name of Patient:							
Date of Birth of Patient:							
Employer/Occupation:							
Residential Address:					Code:		
Postal Address:					Code:		
Contact Numbers:	Office:		Home:		Cell:		
Date of Incident:		Time:		Place:			
Give a detailed description of how the incident happened:							

In the event of a Motor Vehicle Accident, please attach copies of the Police Accident Report, Road Accident Report and Witness Statements (if any)

Section 2: Banking Details for Refunds (if any):

Bank:					
Branch:		Code:		Type:	
Account Holder:				Account No.:	

Section 3: Certificate From Usual/Attending Medical Practitioner (To be completed by the Doctor)

Full Name of Patient:	
Description of Incident:	
Please State Cause and Nature of Disability/Inactivity:	
Does this present ailment relate in any way to previous injuries or pre-existing conditions? If yes, please elaborate:	

Section 4: Please Give Details of any Other Attending Doctor:

Name:					
Telephone Number:					
Address:				Code:	
Please give any other details which you feel may be relevant:					
Signature of Doctor:		**Date:**		**Doctors Full Name:**	

Authorisations to be completed by the Insured person or their legal representative:
I hereby authorise any hospital, physician or other person who has treated me to furnish the Insurer, or their representatives, with all the information with regard to any injury, sickness, medical history, consultations, prescriptions or treatment, including copies of all my hospital or medical records. I agree that a photo/fax copy of this authorisation shall be accepted as the original.

Date:		Place:		Capacity:	
Signature of the individual granting authorisation:					

The original first page of the Hospital Bill is to be submitted with this claim form.

In respect of Accident claims, all in-hospital bills are to be submitted as and when they become available.

Please note that you have 4 months to claim after the admission date.

Signed by the Eligible Member on this _____ day of _____ 20 _____ at _____

SIGNATURE: _____ NAME: _____

Section 5: Authority to Make Payment

Dear Sir/Madam

AUTHORITY TO MAKE PAYMENT - AFFINITY HEALTH

WELLNESS FUND HEALTH PLAN MEMBERSHIP NUMBER: _____

I hereby confirm that I _____ as the Eligible Member of the NBCRFLI Wellness Fund Health Plan hereby authorise National Risk Managers (Pty) Ltd, on behalf of the Insurer, to pay the stated benefits due to me in terms of the policy to the service provider concerned. I acknowledge that any outstanding amounts owed to the service provider over and above the benefit payable by Affinity Health will be for my account.

I record that this is a power of attorney authorising National Risk Managers (Pty) Ltd to make payment of my funds as directed by me and is a cession of any benefits in terms of the Wellness Fund Health Plan.

SIGNATURE OF ELIGIBLE MEMBER _____

Signed by the Eligible Member on this _____ day of _____ 20 _____ at _____

Claim Forms may be forwarded to us via
Email: hospitalclaims@nbcrflihealth.co.za or Fax: 086 480 6809