CLAIM REFUND FORM

MANDATORY FIELD

Date: D D M M Y Y Y Y

Member Details

Name of Patient:

LMHS CARD NO.

Name and Bank Account Details of Principal Member/ Staff

Account Name:

Bank Name:

Branch:

Account Numuber:

Email:

Member Phone Number:

Member signature:

1. *Refunds are permitted ONLY FOR EMERGENCIES and must have PRE-AUTHORISATION CODES.*
2. *Claim refunds are vetted before they are paid. Please ensure that all relevant documents to support the claim are attached.*
3. *Refunds are to be submitted for processing within 3 months of receiving medical attention after which they go stale.*
4. *Stale claim Refunds cannot be honoured*

Relevant Documents Attached (PLEASE TICK)

Prescription: ☐ Referral Note: ☐ Receipts: ☐ Laboratory Request: ☐

Name of Health Facility	**Amount:**
1.	
2.	
3.	
4.	
5.	
TOTAL:	

REFUND PROTOCOL

Kindly note the requirements for a successful claim refund reimbursement.
When you file for the following refunds ensure that the following documents accompany your claim.

- ***GP/SP CONSULTATION SERVICES*** - Attach a clinical or medical detail from your Doctor (Diagnosis is mandatory).
- ***LABORATORY TESTS*** - Attach a laboratory request form recommended by the Doctor and an itemized receipt per test cost.
- ***RADIOLOGY TESTS*** - Attach a radiology request form recommended by the Doctor and an itemized receipt per service received.
- ***MEDICATION*** - Attach the medication prescription prescribed by the Doctor and an itemized cost per medication served.
- ***IN-PATIENT CASE*** - Attach an itemized bill from the hospital for every service received in detail.

For ALL the situations stated above it is required of you to provide a detailed bill and receipts covering each payment for services obtained at the health facility.

Peace of Mind............Always.