Alliance | health

Claim Form

Please ensure that all of the sections of this form are completed. Where a section is not applicable, please indicate as such by using the symbols N/A. **Payments of claims will be delayed by incomplete or illegible information**. This form must be returned to Alliance Health **within 3 months of treatment**. Please enclose ALL original invoices, receipts and statements. Tick the box where required.

Payment of this claim should be made to: 1. The member ☐ **2. The service provider** ☐

Please Complete The Section Below With The Details Of The Person Undergoing Treatment		
Membership Number:	**Suffix:**	**Plan /Scheme:**
Company or Group Name:		
Patient's Full Name:		Date of Birth: DD / MM / YYYY
Residential Address:		
Contact Number(s):		
Email Address:		
In which country did the INITIAL treatment take place?		
In which country did the MAIN treatment take place?		
What is the **total amount** of the claim?	USD ☐ ZAR ☐ OTHER (specify) ☐	

The Section Below Should Be Completed By The Main Medical Practitioner/Dentist/Optician		
NB: The Medical History of this Condition and the Treatment:-	**Dates**	
***When were symptoms of this condition first noticed by the patient?**	DD / MM / YYYY	****Critical**
***When did the patient first seek advice/treatment for this condition?**	DD / MM / YYYY	**Information***
For all SPECIALIST, THERAPIST and DIAGNOSTIC CLAIMS: - **Please indicate the name of the original referring doctor:**		

****Without this information the claim cannot be processed****

Symptoms			ICD 10 CODES	ZRVS/AHFoZ TARIFF CODES	MOD	QUANTITY	DATE OF TREATMENT	FEES CHARGED
Diagnosis:								
Acute Gastroenteritis		Other Diagnosis (Please detail below)						
Appendicitis								
Bronchitis								
Pharyngitis								
Sinusitis								
Tonsillitis								
URTI								
UTI								
Soft Tissue Injury								
MVA/RTA Injury								
		Miscellaneous Expenses:						

Medical Practitioner's Stamp:		**If not already detailed in the stamp:** Name:
		Email address:
		AHFoZ Payee Number:
Signature:	Date:	Contact Number:
Attending Specialist's / Physician's name (if any):		Claim Reference Number:
Anesthetist's name (if any):		Date Claim Closed:

I, the undersigned, on behalf of myself and my dependants hereby irrevocably authorise and request any hospital, specialist, physician, doctor or any other health provider to furnish ALLIANCE HEALTH or its duly appointed and authorised agent acting on ALLIANCE HEALTH's behalf, with such information as may be requested from them with regards to any symptoms experienced or advice, treatment or other services provided to me or my dependant, and I understand and accept that by not doing so I will prejudice any potential recoveries to me or my dependants. I declare that the information provided on this form is accurate and correct to the best of my knowledge. (*If the patient is under the age of 18 years attained, a parent or guardian is to sign.)*

Signature ______________________________ Date ____________________________

NB: ***Please turn overleaf and provide current bank details to which the claim should be reimbursed. Without this information, the claim payment might be delayed. Member claims to be accompanied by copy of referral letter for specialist treatments/visits & lab tests.***

Account Details for claim payment:

Account Name																															
Account																															
Bank Name																															
Branch Name																															
Country																															
Branch Code																															
SWIFT/BIC Code																															

Written communications and fully completed claim forms can be delivered to:

7 Fleetwood Road
Alexandra Park
Harare

Alliance health

www.alliancehealth.co.zw