Scheme:

THE EMPLOYEE / DEPENDENT

(If employee membership card available show impression in box and leave following items blank)

Name: Sex: Male / Female

……..

(Delete as applicable)

Badge or Employee Number: ……..

Date: …… / …… / ……

Signature of Claimant ……..……

TREATMENT INFORMATION

Date of Injury or
Commencement of Illness: ……

Date of consultation: ……

Date first seen (if ongoing treatment): ……
Diagnosis: ……
……
……
……

Services Rendered:
(e.g. Consultation, tests or investigations etc.)
……
……

Drugs Prescribed: ……
……

Is ongoing treatment required in respect of this condition?

YES / NO

delete as applicable

If yes, what additional treatment, tests or other investigations do you anticipate being necessary?
……
……
……

ACCOUNTING INFORMATION

Doctor's fee ……

Drugs ……

X - Rays ……

Laboratory ……

Other (Please give details)
……
……
……
……

Total ……

NOTE TO THE SCHEME MEMBER
To obtain reimbursement this form must be given to your employer together with confirmation of payment

Name of Hospital
……
Name of treating Doctor
……

Signed …… Date
……

Third Party Administrator: **Medi Visa**