

# Claim form for medical costs incurred outside South Africa



## Contact details

Tel: 0860 116 116 • PO Box 652509, Benmore 2010 • [www.yourremedi.co.za](http://www.yourremedi.co.za)

Please complete this form if you want to request additional cover for your approved Chronic Disease List Condition.

## Who we are

Remedi Medical Aid Scheme, registration number 1430 is a not-for-profit organisation registered with the Council for Medical Schemes, and is the medical scheme that you are a member of.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, is a separate company and an authorised financial services provider and is the Administrator and managed care organisation for Discovery Health Medical Scheme and takes care of the administration of your membership.

## How to complete this form

1. Please use one letter per block, complete with black ink and print clearly.
2. Email the completed and signed form to [chronicapplications@yourremedi.co.za](mailto:chronicapplications@yourremedi.co.za).
3. To avoid administrative delays, please ensure this form is completed in full by you and your doctor.

## 1. Travel and personal information

Membership number

Departure date           Return Date

Do you live outside the borders of SA? Yes  No

Did you buy your ticket by credit card? Yes  No

If "Yes", please supply the name of your bank

Do you have independent travel insurance? Yes  No

Member's surname

Member's first names (as per identity document)

Member's date of birth

Postal address (Post collected from post box, suite or private bag)

PO Box  Private Bag Box number

Suite  Postnet Suite Number

Suburb  Postal code

If your post is delivered to your street address, please complete these details under physical address.

Physical address

Unit/Suite number  Complex name

Street number  Street name

Suburb

City  Postal code

Telephone (H)   Telephone (W)

Cellphone

Email

## 2. Details of medical aid related expenses

Date of illness/injury/admission to hospital

Country of illness/injury

Cause of illness/injury/diagnosis/symptoms

Treatment or medication received

Full name of doctor consulted

Name of hospital admitted to

Total amount claimed for foreign currency

Foreign currency (for example US dollars, Euros)

Did you settle these accounts yourself? Yes  No

Have you previously received treatment or attention for this illness/condition in South Africa? Yes  No

## 3. Details of your treating doctors in South Africa

Doctor's name

Telephone

Doctor's name

Telephone

Brief explanation of medical incident (Cause of illness/injury, dates of admission and discharge, medication and treatment given.)

Date of service	Dependant	Treatment	Claimed amount
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## Declaration

I declare that the above information is true in every respect.

Signature

Date

Please only sign if information is true, complete and correct.