

**Contact details**

Tel: 0860 123 077 • PO Box 652509, Benmore 2010 • [www.tfgmedicalaidscheme.co.za](http://www.tfgmedicalaidscheme.co.za)

## Request to reverse the payment of a claim that TFG Medical Aid Scheme received and paid

This form is to ask TFG Medical Aid Scheme (referred to as ‘the Scheme’), to reverse a payment that we made to you or to a healthcare provider.

**Who we are**

TFG Medical Aid Scheme (referred to as ‘the Scheme’), registration number 1578, is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as ‘the administrator’) is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Scheme.

**How to complete this form**

1. Please use one letter per block, complete in black ink and print clearly.
2. Please ensure the main member signs and dates the form.
3. Once complete, please email it to [claimsadjustments@discovery.co.za](mailto:claimsadjustments@discovery.co.za)

**When you sign this application, you confirm that you have read and understood the requirements and that the information is true and complete.**

**1. About the main member**

Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
Identity or passport number	<input type="text"/>		
Date of birth	<input type="text"/>		
Membership number	<input type="text"/>		
Telephone (H)	<input type="text"/>	Telephone (W)	<input type="text"/>
Cellphone	<input type="text"/>		<input type="text"/>
Email	<input type="text"/>		

**2. About the claim that you want the Scheme to reverse**

Details of the claim that the Scheme paid and that you want reversed:

Service date	<input type="text"/>	Practice number	<input type="text"/>
Practice name or name of healthcare provider	<input type="text"/>		
Healthcare service	<input type="text"/>		
Amount Claimed	<input type="text"/>	Amount that the Scheme paid	<input type="text"/>

Please give a brief explanation of why you want us to reverse this payment

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

### 3. Important information about your request to reverse payment of a claim

1. Please be aware that when we reverse the payment we made for this healthcare service, the healthcare provider may still hold you responsible for the payment.
2. You agree that when the Scheme reverses the payment we made to you or to the provider, we will not process or pay this claim again.
3. You agree that we let the Healthcare Provider know of your request to have this payment reversed. We may also give this confirmation to the Healthcare Provider in writing.
4. Any misrepresentation of the reason/s for the reversal/s could lead to the termination of your membership.

Main member's name

Main member's signature

Date

Y	Y	Y	Y	M	M	D	D
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**Please do not sign an incomplete application form**