

Request to reverse the payment of a claim paid by MEDiPOS Medical Scheme



Contact us

Tel: 0860 100 078 • PO Box 652509, Benmore 2010 • www.medipos.co.za

This form is to ask MEDiPOS Medical Scheme, to reverse a payment that we made to you or to a healthcare provider.

Who are we

MEDiPOS Medical Scheme (referred to as 'the Scheme'), registration number 1548, is a not-for-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 to the Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly. Alternatively, complete it electronically by typing in the fields below.
2. Please ensure that the main member signs the form.
3. Email the completed form to claimsadjustments@medipos.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. Main member's details

Membership number	<input type="text"/>
ID or passport number	<input type="text"/>
Member's surname	<input type="text"/>
Member's name	<input type="text"/>

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

Details of the claim paid by the Scheme that you wish to be reversed:

Service date	<input type="text"/>	Practice number	<input type="text"/>
Healthcare provider	<input type="text"/>		
Practice name	<input type="text"/>		
Claim reference number (if available)	<input type="text"/>		
Healthcare service	<input type="text"/>		
Amount claimed	R	<input type="text"/>	<input type="text"/>
Amount that the Scheme paid	R	<input type="text"/>	<input type="text"/>

Please give a brief explanation as to why you want the payment for this healthcare service reversed

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

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

1. Please be aware that once we reverse the payment made for this healthcare service, the healthcare provider may still hold you responsible for the payment of this amount.
2. You agree that once the Scheme reverses the payment made to you or to the provider, we will not process or pay this claim again.
3. You agree that we advise the healthcare provider 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

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