

1. IMPORTANT INFORMATION / BELANGRIKE INLIGTING

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| <ol style="list-style-type: none"> 1. This form is only applicable to out-of-network family practitioner (FP) and casualty claims. 2. Benefits are limited to the rules of your option. 3. Please pay the claim upfront before submitting for reimbursement. 4. You will need to submit your fully specified claim including receipts of payments made, as well as this form via e-mail to pulsenetworks@bestmed.co.za or via fax to 012 818 9004. 5. All claims must be submitted within 4 months from the date of service. Any claims submitted after this period will be invalid and will not be reimbursed. 6. The principal member's banking details are compulsory to ensure seamless processing and refund of valid claims. 7. Please keep copies of all documentation as well as the proof of submission. 8. Please note the completion of banking details on this form is for verification purposes only and will not be used for updating of banking details with the scheme. | <ol style="list-style-type: none"> 1. Hierdie vorm is slegs van toepassing op buite-netwerk familie praktisyn (FP) en ongevalle eise. 2. U voordele is beperk tot die reëls van u opsie. 3. Betaal asseblief u rekening vooraf. Daarna kan u die eis vorm indien vir terugbetaling van u eis. 4. Stuur asseblief 'n e-pos met 'n gedetailleerde rekening, asook 'n bewys van betaling saam met u eisvorm na pulsenetworks@bestmed.co.za of faks die nodige dokumentasie deur na 012 818 9004. 5. Alle eise moet binne vier maande vanaf die datum waarop die diens plaasgevind het ingedien word. Enige eise wat laat ingedien word, sal gesien word as ongeldig en nie betaal word nie. 6. Die hooflid se bankbesonderhede is verpligtend vir die verwerking en terugbetaling van geldige eise. 7. Hou asseblief afskrifte van alle dokumentasie asook die bewys van indiening. 8. Let asseblief daarop dat die voltooiing van bankbesonderhede op hierdie vorm slegs vir verifikasiedoeleindes is en sal nie gebruik word vir die opdatering van bankbesonderhede by die skema nie. |
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2. PERSONAL INFORMATION / PERSOONLIKE INLIGTING

Membership number Lidnommer	<input type="text"/>	Option Opsie	<input type="text"/>
Member surname Lid se van	<input type="text"/>		
Member name Lid se naam	<input type="text"/>		
Tel (W)	<input type="text"/>		
Tel (H)	<input type="text"/>		
Cell number Selfoonnommer	<input type="text"/>		
E-mail E-pos	<input type="text"/>		

3. DETAILS OF CLAIM SUBMITTED FOR PAYMENT / BESONDERHEDE VAN EIS INGEDIEN VIR BETALING

Practice number Praktyknommer	<input type="text"/>								
Provider name Naam van verskaffer	<input type="text"/>								
Service Date Diensdatum	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; text-align: center;">D</td> <td style="width: 20px; text-align: center;">D</td> <td style="width: 20px; text-align: center;">M</td> <td style="width: 20px; text-align: center;">M</td> <td style="width: 20px; text-align: center;">Y</td> <td style="width: 20px; text-align: center;">Y</td> <td style="width: 20px; text-align: center;">Y</td> <td style="width: 20px; text-align: center;">Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		

4. PRINCIPAL MEMBER'S BANK DETAILS FOR REIMBURSEMENT PURPOSES / HOOFID SE BANKBESONDERHEDE VIR TERUGBETALINGSDOELEINDES

I declare that the bank details on this verification form are correct and may be used by Bestmed for the reimbursement of valid claims.
 Ek verklaar dat die bankbesonderhede op hierdie bewys van betalingsvorm korrek is en gebruik mag word deur Bestmed vir die terugbetaling van geldige eise.

Account holder / Rekeninghouer:

Bank / Bank:

Branch code / Takkode:

Type of account / Tipe rekening

Cheque / Tjek

Savings / Spaar

Please circle the relevant blocks and print **YOUR ACCOUNT NUMBER** in the **last row**
 Omsirkel asseblief die betrokke blokkies en skryf u **REKENINGNOMMER** in die **laaste ry**

0	0	0	0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9	9	9	9

Principal member's signature / Hooflid se handtekening _____

Date / Datum:

D	D	M	M	Y	Y	Y	Y
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