PROFMED

INTERNATIONAL TRAVEL CLAIM FORM

ATTENTION: PROFMED INTERNATIONAL CLAIMS
Please submit this completed claim form and documentation to Profmed.

Email: internationalclaims@profmed.co.za
Postal address:
PO BOX 1031
Lyttelton
Centurion
0140

1. The issuing of this claim form does not imply an admission of liability by Profmed or its agents.
2. This claim will be assessed in terms of the rules of the Scheme and protocols of the designated service provider.
3. Any funds reimbursed will be paid into the member's bank account on record with Profmed.
4. The member is responsible for any fees in connection with the submission and completion of this form and any other documents required by the Scheme, and in support of this claim.
5. Only a fully completed and signed claim form, submitted with the required documentation, can receive our full attention.
6. Please complete **ALL** questions. If any question/s is not applicable, please state "N/A".
7. Please attach to this claim form copies of the following documents:
   a. Identity document of the member and claimant/patient
   b. Proof of medical costs incurred, e.g. invoices and receipts
   c. Medical report from the attending doctor
   d. Copy of your travel ticket or other relevant proof of the length of journey on which the medical event occurred.

1 PERSONAL DETAILS

Full name of claimant/patient:

ID number: | | | | | | | | | | | | | Age: Mr/Dr/Mrs/Miss:

Full name and surname of member:

Membership number: Profmed Benefit option:

Cell no.: Tel. no.: Email:

Postal address: Postal code:

How did you pay for your travel ticket – cash or credit card? ☐ Cash ☐ Credit card

Bank: Credit card no.:

2 MEDICAL CLAIMS

Place and date where the illness/injury occurred: Place:

Date: D D M M Y Y Y Y Currency paid in: Amount claimed:

(Please ensure proof of payment/receipts is attached to the medical claims)

Did you consult a medical practitioner? Y N Name of practitioner:

Tel. no.: Fax no.:

Were you admitted to hospital as an in-patient? Y N If yes, please specify:

Have you ever received treatment for this or a related illness: Y N

*If **YES**, please attach medical practitioner's report stating what treatment was received within 24 months prior to the commencement of your journey.*

Name and telephone number of your local medical practitioner:

Name: Tel. no.:

Did you notify the designated service provider that you require treatment? Y N

If **YES**, when and where?

If **NO**, please give reasons why not:

FOR OFFICE USE
Rand exchange value:
Date of exchange:
Authorised for payment:

3 DECLARATION AND AUTHORITY

I hereby declare that all the information provided on and with this claim form is correct and true in every respect and that the signing of this claim form also constitutes written authority for the Scheme to inspect or investigate any medical records or details relevant to this claim. I further declare that I am aware that any misrepresentation and/or non-disclosure in respect of information provided herein shall render the claim null and void.

I authorise any medical practitioner, hospital or other person to provide Profmed and/or the designated service provider with any information required relating to the medical history and illness/injury to which this claim relates. I agree that this consent shall remain in force at all times, and that a photocopy or fax of this declaration shall be accepted as the original. I agree and accept that Profmed and/or the designated service provider can request additional information from any medical practitioner, hospital or any other person in relation to this claim not specifically requested herein, on completion and submission of this form and any other documentation as submitted by me.

Member's signature _____ Date D D M M Y Y Y Y