PAY FROM ACCUMULATED SAVINGS APPLICATION FORM

A. IMPORTANT INFORMATION

1. Please use one letter per block, complete with black ink and write clearly.
2. Please ensure that the form is completed in full to avoid administration / payment delays.
3. Payments can only be made to registered providers - providers registered with the Board of Healthcare Funders (BHF) and have a BHF practice number.
4. Payment can only be made for a valid and recognised medical procedure, treatment (with tariff codes) and medication (with NAPPI codes).
5. Payment can only be made for expenses already incurred and not towards future payments or quotations.
6. Send completed forms via fax **(041) 395 4596**, mail **PO Box 1672, Port Elizabeth, 6000** or e-mail **suremed@providence.co.za.**

B. DETAILS OF PRINCIPAL MEMBER

Membership Number

Surname | First Names

Title | Date of Birth Y Y Y Y M M D D | ID Number

Telephone number (Home) | (Work)

Fax number (Confidential) | Cellular

Email address (Confidential)

Postal Address

Code

C. DETAILS OF THE PATIENT(Beneficiary who received the services or medication)

Surname | First Names

Title | Date of Birth Y Y Y Y M M D D | ID Number

Telephone number (Home) | (Work)

Fax number (Confidential) | Cellular

Email address (Confidential)

D. DETAILS OF THE CLAIM

Dates of treatment 2 0 Y Y M M D D to 2 0 Y Y M M D D

2 0 Y Y M M D D to 2 0 Y Y M M D D

Name of service provider | Practice No

Practice No

Practice No

Practice No

Practice No

Total amount requested to be paid R

Description of treatment

The scheme will not be held responsible for any consequences (whether medical, financial or otherwise), that may result from the healthcare service claimed by you.

Name of service provider

Signature of principal member ______________________ Date 2 0 Y Y M M D D

SABS ISO 9001

Administered by PROVIDENCE Healthcare Risk Managers (Pty) Ltd. Reg. No.1993/006699/07
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