GETMED HEALTH PROTECTION PLAN
CLAIM SUBMISSION FORM

The Claims Manager
GetMed
68 Oak Ave, Highveld Techno Park, Centurion, 0046
P.O. Box 10999, Centurion, 0046
Tel: 012 682 8000 Fax: 012 682 8023

Please attend to the claims submitted below:

MEMBER DETAILS

EMPLOYER NR		**MEMBERSHIP NR**	

Title:		**Initials:**		**Surname:**	

Claims details

Provider name / Practice nr	Patient name / Date of birth	Date of service	Authorisation nr	Amount

Bank details of Member

Account holder name			
BANK		**BRANCH CODE**	
ACCOUNT NUMBER		**ACCOUNT TYPE**	
GetMed Account number for reference purposes:			
MEMBER SIGNATURE:		**SIGNATURE DATE**	D D M M Y Y Y Y

Please Note:

1. GetMed accepts the claims listed in this form subject to:
    a. The claims will be validated by the GetMed claims department;
    b. The amounts payable to the member will be limited to the option rules;
    c. Where the claim is submitted without any valid authorisation issued by GetMed to the provider the claim will not be considered for payment.