CLAIM FORM FOR THE REIMBURSEMENT OF *OUT OF NETWORK OR **EMERGENCY GP CONSULTATIONS

Important Notes and Instructions

1. An *out of network consultation refers to a consultation at a non-CareCross General Practitioner while an **emergency consultation is where immediate medical treatment was required and your CareCross GP was not available.
2. This benefit is limited to **3 visits per family per annum to a maximum of R1 000 per family per annum.** The limit includes the costs for the general practitioner consultations, procedures, medication, radiology and pathology. **Please note** that facility fees are not covered.
3. You will be required to pay the accounts upfront before submitting for reimbursement. You will also be responsible for attaching the detailed accounts as well as the receipts for the payments you have made in respect of the visit.
4. Members are allowed a period of four months from date of treatment in which to submit the claim for payment. Once the four month period has lapsed the claim becomes stale and will not be paid.
5. Refunds are by Electronic Fund Transfer (EFT) only. Your **bank details** are thus **compulsory** in ensuring that you receive the funds due to you.
6. Please keep copies of all documents as well the proof of the submission.
7. Post the documentation to: **CareCross Health, P.O. Box 44991, Claremont, 7735 or email to reimbursements@carecross.co.za**
8. Payments are made within 30 days from date of receipt and will be reflected on your remittance statement.

Section A: Personal information	
Medical Scheme Name	
Membership Number	
Full Name of Member	
Telephone number	

Section B: Bank details for the reimbursement of funds (COMPULSORY)				
Please note that we do not accept credit card details				
Name of Account Holder				
Type of Account	**Cheque Account**		**Savings Account**	
Bank				
Branch Name				
Branch Code				

Account Number

Please print your account number in the first row and circle the matching number in the block below.

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

Section C: Details of claims submitted for payment				
Details required	**Account 1**	**Account 2**	**Account 3**	**Account 4**
Name of Doctor				
Practice Number				
Treatment Date				

Signed:_____ **Date:** _____

Please complete all sections. Only receipted accounts will be considered.