

# Member Refund Form

In the event of any member requiring a refund, this form must be completed.

## Please attach the following documents to your claim

1. **Detailed account** from your service provider and a **receipt**
2. Pharmacy claim: a **script print out**, and a **cash slip**
3. **Copy of ID** and **Bank Confirmation Letter**/Current Bank Statement

Please email your claim to: **claims@nationalhealthcare.co.za**

Date completed:

Member Surname:

Policy Number:

Identity Number:

Patient Name:

Date of Birth:

Name of service provider:

Practice Number:

Date of service:

Reason for refund:

Amount charged:  Amount paid:

## MEMBER BANKING DETAILS

Account name:

Account no:

Bank:

Branch:  Branch code:

Contact number: (work)  Cell phone:

Member signature:

Refunds will be paid within 30 days after receipt of the relevant documentation.