

# Claim form for medical costs incurred outside South Africa

## How to complete this form

- Please complete this form when claiming for any emergency medical expenses incurred while travelling outside South Africa (SA), in accordance with the Scheme rules.
- Please note: as the Prescribed Minimum Benefits do not apply beyond the borders of SA, all claims will be covered at the applicable Scheme rate for the specific treatment and all limitations will apply.
- Please use one letter per block, complete with black ink and print clearly.
- To avoid administration delays, please make sure this form is completed in full.
- Please submit all supporting claims or documents to LA Health Medical Scheme with this form.
- You need to report/submit all claims in 60 days of your return to SA or in three months, if you live outside the borders of SA.
- Please attach a copy of passport with entry and exit stamps or tickets.
- Please fax the completed form to **0860 329 252**.

## 1. Travel and personal information

Membership number

Departure date           Return date

Do you live outside the borders of SA? Yes  No

Did you buy your ticket by credit card? Yes  No

If "Yes", please supply the name of your bank

Do you have independent travel insurance? Yes  No

Member's surname

Member's first names

Member's date of birth

Postal address   
  
 Code

Physical address   
  
 Code

Telephone (W)       Fax

(H)       Cellphone

Email

## 2. Details of medical and related expenses

Date of illness/injury/admission to hospital

Country of illness/injury

Cause of illness/injury/diagnosis/symptoms

Treatment or medicine received

Full name of doctor consulted

Name of hospital admitted to

Foreign currency amount spent

Foreign currency (for example US dollars, Cypriot pounds)

Did you settle these accounts yourself? Yes  No

Have you previously received treatment or attention for this illness/condition in South Africa? Yes  No

### 3. Details of your treating doctors in South Africa

|               |                      |                      |     |                      |                      |  |  |  |  |  |  |  |  |  |  |  |
|---------------|----------------------|----------------------|-----|----------------------|----------------------|--|--|--|--|--|--|--|--|--|--|--|
| Doctor's name | <input type="text"/> |                      |     |                      |                      |  |  |  |  |  |  |  |  |  |  |  |
| Telephone     | <input type="text"/> | <input type="text"/> | Fax | <input type="text"/> | <input type="text"/> |  |  |  |  |  |  |  |  |  |  |  |
| Doctor's name | <input type="text"/> |                      |     |                      |                      |  |  |  |  |  |  |  |  |  |  |  |
| Tel           | <input type="text"/> | <input type="text"/> | Fax | <input type="text"/> | <input type="text"/> |  |  |  |  |  |  |  |  |  |  |  |

Brief explanation of medical incident (Cause of illness/injury, dates of admission and discharge, medication and treatment given.)

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|    | Date of service      | Dependant            | Treatment            | Claimed amount       |
|----|----------------------|----------------------|----------------------|----------------------|
| 1. | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 2. | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 3. | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 4. | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 5. | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 6. | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

### 4. Declaration

I declare that the above information is true in every respect.

Name in full

Signature

Date