Alliance HEALTH
Healthcare Solutions

Claim Form

Please ensure that all of the sections of this form are completed. Where a section is not applicable, please indicate as such by using the symbols N/A. **Payments of claims will be delayed by incomplete or illegible information**. This form must be returned to Alliance Health **within 3 months of treatment**. Please enclose ALL original invoices, receipts and statements. Tick the box where required.

Payment of this claim should be made to: 1. The member ☐ **2. The service provider** ☐

Please Complete The Section Below With The Details Of The Person Undergoing Treatment		
Membership Number:	**Company or Group Name:**	**Plan /Scheme:**
Patient's Full Name:	Date of Birth: D D / M M / YYYY	
Residential Address:		
Contact Number(s):		
Email Address:		
In which country did the INITIAL treatment take place?		
In which country did the MAIN treatment take place?		
Which is the currency of the invoices? USD ☐ ZAR ☐ OTHER (specify)		
What is the total amount of the claim?		

The Section Below Should Be Completed By The Main Medical Practitioner/Dentist/Optician		
NB: The Medical History of this Condition and the Treatment:-	**Dates**	
***When were symptoms of this condition first noticed by the patient?**	D D / M M / YYYY	****Critical**
***When did the patient first seek advice/treatment for this condition?**	D D / M M / YYYY	**Information***
For all SPECIALIST, THERAPIST and DIAGNOSTIC CLAIMS: - Please indicate the name of the original referring doctor:		

****Without this information the claim cannot be processed****

Symptoms			**ICD 10 CODES**	**ZRVS/AHFoZ TARIFF CODES**	**DATE OF TREATMENT**	**FEES CHARGED**
Diagnosis:		Other Diagnosis (Please detail below)				
Acute Gastroenteritis						
Appendicitis						
Bronchitis						
Pharyngitis						
Sinusitis						
Tonsillitis						
URTI						
Soft Tissue Injury						
MVA/RTA Injury						

Miscellaneous Expenses:

Medical Practitioner's Stamp:	**If not already detailed in the stamp:** Name:
	Email address:
	AHFoZ Payee Number:
Signature: Date:	Contact Number:
Attending Specialist's / Physician's name (if any):	Claim Reference Number:
Anesthetist's name (if any):	Date Claim Closed:

I, the undersigned, hereby authorise and request any hospital, specialist, physician, doctor or any other health provider to furnish ALLIANCE HEALTH or its duly appointed and authorised agent acting on ALLIANCE HEALTH's behalf, with such information as may be requested from them with regards to any symptoms experienced or advice, treatment or other services provided to me or my dependant. I declare that the information provided on this form is accurate and correct to the best of my knowledge. (*If the patient is under the age of 18 years attained, a parent or guardian is to sign.)*

Signature _____ Date _____

NB: ***Please turn overleaf and provide current bank details to which the claim should be reimbursed. Without this information, the claim payment might be delayed. Member claims to be accompanied by copy of referral letter for specialist treatments/visits & lab tests.***

Account Details for claim payment:

Account Name																													
Account																													
Bank Name																													
Branch Name																													
Country																													
Branch Code																													
SWIFT/BIC Code																													

Written communications and fully completed claim forms can be delivered to:

7 Fleetwood Road
Alexandra Park
Harare

Alliance HEALTH
Healthcare Solutions

www.alliancehealth.co.zw