

Request to reverse the payment of a claim that SAB Medical Aid received and paid



Contact details
Tel: 0860 002 133 • www.sabmas.co.za

Who we are

SAB Medical Aid (referred to as 'the Scheme'), registration number 1209, is a not-for-profit organisation, registered with the Council for Medical Schemes. Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the Administrator') is a separate company and an authorised financial services provider and is responsible for the administration of your membership on behalf of the Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly. Alternatively, complete it digitally.
2. Please email this completed and signed form with any supporting documents to claimsadjustments@sabmas.co.za.
3. Please make sure the principal member signs and dates the form.

By signing this application, you confirm that you have read and understood the rules for membership and agree to them (available on the Scheme's website at www.sabmas.co.za).

1. About yourself (principal member)

Title		Initials	
Surname			
First name(s) (as per identity document)			
ID or passport number		Membership number	
Telephone (H)		Telephone (W)	
Cellphone			
Email			

2. About the claim that you want the Scheme to reverse

Service date		Practice number	
Practice name			
Healthcare professional name			
Claim reference number (if available)			
Healthcare service			
Amount claimed	R	Amount that the Scheme paid	R

Please give a brief explanation of why you want us to reverse this payment

3. Important information about your request to reverse payment of a claim

- 1. Please be aware that when we reverse the payment we made for this healthcare service, the healthcare professional may still hold you responsible for the payment.
- 2. You agree that when the Scheme reverses the payment we made to you or to the healthcare professional, we will not process or pay this claim again.
- 3. You agree that we let the healthcare professional know of your request to have this payment reversed. We may also give this confirmation to the healthcare professional in writing.
- 4. Any misrepresentation of the reason/s for the reversal/s could lead to the termination of your membership.

Principal member's name

Principal member's signature

Date

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Please do not sign an incomplete application form