Request to reverse the payment of a claim that LA Health Medical Scheme received and paid

LA Health
Powered by Discovery

Contact details
Tel: 0860 103 933 • PO Box 652509, Benmore 2010 • www.lahealth.co.za

This form is to ask LA Health Medical Scheme (referred to as 'the Scheme'), to reverse a payment that we made to you or to a healthcare provider.

Who we are

LA Health Medical Scheme (referred to as 'the Scheme'), registration number 1145, is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. Please ensure the main member signs and dates the form
3. Once complete, please fax your form to 0860 235 878 or email it to **claimsadjustments@discovery.co.za**

When you sign this application, you confirm that you have read and understood the requirements and that the information is true and complete.

1. About the main member

Title | Initials | Surname

Identity number | Date of birth (Y Y Y Y M M D D)

Passport number | Membership number

Telephone (H) | (W)

Cellphone | Fax

Email

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

Details of the claim that the Scheme paid and that you want reversed:

Service date (Y Y Y Y M M D D) | Practice number

Practice name or name of healthcare provider

Claim reference number (if available)

Healthcare service

Amount claimed | Amount that the Scheme paid

Please give a brief explanation of why you want the payment for this healthcare service reversed

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 provider may still hold you responsible for the payment of this amount.
2. You agree that when the Scheme reverses the payment we made to you or to the provider, we will not process or pay this claim again.
3. You agree that we let the healthcare provider know of your request to have this payment reversed. We may also give this confirmation to the healthcare provider in writing.

Main member's name

Main member's signature | Date (Y Y Y Y M M D D)

Please do not sign an incomplete application form