Contact us
Tel: 0800 BANKMED (0800 226 5633) • Private Bag X2, Rivonia 2128 • www.bankmed.co.za

International claim form

Who we are

Bankmed (referred to as 'the Scheme'), registration number 1279, 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) which takes care of the administration of your membership for the Scheme.

How to complete this form

1. Kindly complete this form when claiming for any medical expenses incurred while travelling overseas.
2. Use black ink. Print clearly with one letter per block, alternatively, complete it electronically by typing in the fields below.
3. To avoid administration delays, kindly ensure this form is completed in full.
4. Submit all medical claims and supporting documentation (Proof of payment per medical invoice and proof of travel-copy of ticket or passport).
5. You are required to report/submit all claims within 60 days of your return to South Africa or within five months, should you be living outside the borders of SA.
6. Please attach a copy of your passport with entry and exit stamps or air tickets.
7. To submit your claim, please e-mail completed form to **claims@bankmed.co.za** or fax to **021 527 1940**.
8. To follow up, contact **0800 BANKMED (0800 226 5633)**.
9. Please submit all correspondence and claims in English as the Scheme and administrator do not offer translation services.

1. Travel and personal information

Membership number | Reference number

Departure date (D D M M Y Y Y Y) | Return date (D D M M Y Y Y Y)

Did you purchase your ticket by credit card? Yes ☐ No ☐

Should you have indicated yes, kindly supply the name of your bank

Do you have medical cover in your current place of residence? Yes ☐ No ☐

Patient's surname

Patient's first name(s)

Patient's date of birth (Y Y Y Y M M D D)

Postal address

Code

Physical address

Code

Telephone (W) | Fax

Telephone (H) | Cellphone

E-mail

2. Details of medical aid related expenses incurred

Date of illness/injury/admission to hospital Y Y Y Y M M D D Y Y Y Y M M D D Y Y Y Y M M D D

Country of illness/injury

Cause of illness/injury/diagnosis/symptoms

Treatment or medication received

Full name of Healthcare Professional consulted

Name of hospital

Total amount claimed in foreign currency

eg US dollars, Cypriot pounds

Did you settle these accounts yourself? Yes No

3. Declaration

I declare that the above particulars are true in every respect.

Names in full

Signature

Date Y Y Y Y M M D D

Do not sign incomplete forms