ENGEN | Medical Benefit Fund

Administered by Discovery Health

Contact details
Tel: 0800 001 615 • PO Box 652509, Benmore, 2010 • www.engenmed.co.za

Request to reverse the payment of a claim that Engen Medical Benefit Fund received and paid

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

Who we are

Engen Medical Benefit Fund (referred to as 'EMBF'), registration number 1572, is a non-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, an authorised financial services provider and is responsible for the administration of your membership on behalf of the Fund.

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 email your form to **claimsadjustments@engenmed.co.za** or fax it to 0860 235 878.

When you sign this form, 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 Fund to reverse

Details of the claim that the Fund 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 Fund 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 Fund 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 form