

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	<input type="text"/>	Initials	<input type="text"/>	Surname	<input type="text"/>
Identity number	<input type="text"/>	Date of birth		<input type="text"/>	<input type="text"/>
Passport number	<input type="text"/>	Membership number		<input type="text"/>	<input type="text"/>
Telephone (H)	<input type="text"/>	(W)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Cellphone	<input type="text"/>	Fax	<input type="text"/>	<input type="text"/>	<input type="text"/>
E-mail address	<input type="text"/>				

2. About the claim that you want the Fund to reserve

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

Service date	<input type="text"/>
Practice number	<input type="text"/>
Practice name or name of Healthcare Provider	<input type="text"/>
Claim reference number (if available)	<input type="text"/>
Healthcare service	<input type="text"/>
Amount claimed	R <input type="text"/> . <input type="text"/>
Amount that the Fund paid	R <input type="text"/> . <input type="text"/>

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

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

1. Please be aware that once we reverse the payment made for this healthcare service, the Healthcare Professional may still hold you responsible for the payment of this amount.
2. You agree that once the Fund reverses the payment made to you or to the provider, we will not process or pay this claim again.
3. You agree that we advise the healthcare provider 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

D	D	M	M	Y	Y	Y	Y
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Please do not sign incomplete forms.