

Who we are

Discovery Health Medical Scheme (referred to as 'the Scheme'), registration number 1125, is the medical scheme that you are applying to become a member of. This is a not-for-profit organisation, registered with the Council for Medical Schemes (CMS).

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 the administrator and managed care organisation for Discovery Health Medical Scheme and takes care of the administration of your membership.

Contact us

Tel (members): 0860 99 88 77, Tel (health partner): 0860 44 55 66, PO Box 784262, Sandton, 2146, www.discovery.co.za, 1 Discovery Place, Sandton, 2196.

Purpose

Complete this form if you have international medical claims.

What you must do

- Fill in the form in black ink and print clearly, or complete the form digitally.
- Submit all the correspondence in English including claims as the Scheme and the administrator do not offer a translation service.
- All relevant sections must be physically signed by the main member and cannot be signed digitally. The main member must sign and date any changes.
- Please fax or email the following supporting documentation to **0860 329 252** or **+27 11 539 7001**, or email **Claims@Discovery.co.za** with this completed International travel claim form:
 1. Proof of travel dates in the form of air ticket stubs or passport stamps
 2. A detailed invoice/account in English
 - 2.1. If the original invoice/account is in another language, please provide the original invoice/account and a translated version of the account
 - 2.2. The Invoice needs to include the following details: Patient name and surname, the diagnosis, provider details, date of service, treatment description and cost of the treatment
 3. Proof of payment for all attached claims in English.
 4. Confirmation of the diagnosis in a form of a doctor's report/letter in English
- Please make sure you send all claims within 120 days of the date of service to avoid the claims being rejected as late submissions to the Scheme.

1. Travel and personal information

Membership number	<input type="text"/>	Reference number	<input type="text"/>
Patient's surname	<input type="text"/>		
Patient's first names (as per identity document)	<input type="text"/>		
Patient's date of birth	<input type="text"/>	-	<input type="text"/>
Telephone (H)	<input type="text"/>	-	<input type="text"/>
Cellphone	<input type="text"/>	-	<input type="text"/>
Email	<input type="text"/>		
Telephone (W)	<input type="text"/>	-	<input type="text"/>
Fax	<input type="text"/>	-	<input type="text"/>

Physical address while in South Africa

Suite/Unit number	<input type="text"/>	Complex name	<input type="text"/>
Street number	<input type="text"/>	Street name	<input type="text"/>
Suburb	<input type="text"/>	Post code	<input type="text"/>

Postal address (Post collected from post box, suite or private bag)

If you do not complete a postal address, we will use your physical address for post.

PO Box Private Bag Box number
 Suite Private Bag Number
 Suburb Post code

Departure date - -
 Return date - -

Are you living outside the borders of SA? Yes No

Did you purchase your ticket by credit card? Yes No

If yes, please supply the name of your bank

Do you have independent travel insurance? Yes No

2. Details of medical and related expenses incurred

Date of illness, injury or admission to hospital

Country where illness or injury happened

Full name of doctor consulted

Name of hospital admitted to

Total amount claimed in foreign currency, for example US dollars, euro, etc

Did you settle these accounts yourself? Yes No

Have you received treatment or attention for this illness or condition in South Africa before? Yes No

Brief explanation of medical incident (main reason/s for seeking medical care) and details of cause of illness or injury, for example car accident
(Dates of admission and discharge, medication and treatment received)

	Date of service	Dependant	Treatment	Claimed amount
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

3. Details of your treating doctors in South Africa

1. Doctor's name	<input type="text"/>		
Telephone	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Fax	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
2. Doctor's name	<input type="text"/>		
Telephone	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Fax	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

4. Declaration

I declare that the information I have given is true and correct.

Signed at (town or city) on - -

Signature of main member

 **Please only sign if information is true, complete and correct.**