Alliance health
7 Fleetwood Road, Alexandra Park Harare.
7 Oak Avenue, Suburbs, Bulawayo.
273 Adam Stander Drive, 2nd Floor,
Elephant Walk Shopping Village, Victoria Falls.
Tel: 08677000716 / 0772 126 120

CLAIM FORM

This form must be returned to Alliance Health within **3 months of treatment**.
All sections of this form must be completed in full . Payments of claims will be delayed by incomplete or illegible information.
Please enclose ALL original invoices, receipts and statements.

Payment of this claim should be made to: **1. The member** ☐ **2. The service provider** ☐

Please Complete The Section Below With The Details Of The Person Undergoing Treatment											
Membership Number:						Suffix:		Plan /Scheme:			
Company or Group Name:											
Patient's Full Name:						Date of Birth:	D D / M M / YYYY				
Residential Address:											
Contact Number(s):											
Email Address:											
What is the total amount of the claim?	USD					ZAR			OTHER (specify)		

Member / Patient declaration
By Signing this form I acknowledge that :

1. Signing this claim form for any treatment which has not been provided is a criminal offense.
2. In the situation where I have paid for the treatment myself, I have signed this claim with all sections completed and submitted all relevant receipts with this claim.
3. In the situation where I have not paid for this treatment, I have signed for each day of treatment received and only after the provider has inserted all their charges.

I confirm that the details given above are correct, that the amount claimed herein is not claimable from another source and that the patient is a member of Alliance Health. I authorize the provider of services to disclose the nature of illness to Alliance Health for its confidential use in the process of determining the validity of this claim. I agree that no payment will be made for this treatment unless contributions are received in respect of the treatment period.

Signature	Date	Relationship to member	Fee charged (if known)

For completion by service provider

AHFoZ Number ☐ **Date claim closed** ☐ **Claim Reference number** ☐

Name of referring practitioner (if any)_____
Name of anaesthetist (if any)_____
Name of surgical assistant (if any)_____

ZRVS/AHFoZ TARIFF CODES	MOD	QUANTITY	DATE OF TREATMENT	FEES CHARGED

Diagnosis section
Diagnosis _____ ICD 10 Code _____

Service provider declaration

I hereby certify that I, or members of my staff, have rendered the above services to the above patient. I confirm that the patient treated is the one named on this form. I agree that claiming for services not provided will be regarded as fraudulent and render myself as the service provider, liable to prosecution.
I agree to release any medical information requested of me to Alliance Health for its confidential use in the process of determining the validity of this claim

Signature _____
Date _____
Contact number _____

Official stamp ☐