Request to reverse the payment of a claim that Remedi received and paid

Contact details
Tel: 0860 116 116 • PO Box 652509, Benmore 2010 • www.yourremedi.co.za

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

Who we are

Remedi Medical Aid Scheme is the medical scheme, registration number 1430, which is 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 Remedi membership.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly. Alternatively, complete it electronically by typing in the fields below.
2. Please ensure the main member signs and dates this form.
3. Once complete, please email your form to **claimsadjustments@yourremedi.co.za**.

When you sign this application, you confirm that you have read and understood the requirements and that the information is true and complete.

1. Main member's details

Membership number

ID or passport number

Member's surname

Member's name

2. About the claim that you want the Scheme to reverse

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

Service date D D M M Y Y Y Y

Practice number

Practice name

Healthcare provider name

Claim reference number (if available)

Healthcare service

Amount claimed **R** .

Amount that the Scheme paid **R** .

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 Scheme 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.
4. Any misrepresentation of the reason/s for the reversal/s could lead to the termination of your membership.

Main member's name

Main member's signature

Date D D M M Y Y Y Y

Please do not sign an incomplete application form