International travel claim form 2022

Discovery Health Medical Scheme

Who we are

Discovery Health Medical Scheme, registration number 1125, is a not-for-profit organisation registered with the Council for Medical Schemes, and is the medical scheme that you are a member of.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, 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 partners): 0860 44 55 66, **www.discovery.co.za**, PO Box 784262, Sandton, 2146,
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 signed by the main member.
- Please email the following supporting documentation to **Claims@Discovery.co.za** or through get help on **www.discovery.co.za** under Medical Aid > Get Help > Submit a document and follow the guided steps through our Virtual Agent.

  2.1 Completed International travel claim form

  2.2 Proof of travel dates in the form of air ticket stubs or passport stamps

  2.3 A detailed invoice/account in English

  2.3.1 If the original invoice/account is in another language, please provide the original invoice/account and a translated version of the account

  2.3.2 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

  2.4 Proof of payment for all attached claims in English.

  2.5 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 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 | Reference number

Patient's surname

Patient's first names (as per identity document)

Patient's ID number

Telephone (H) - | Telephone (W) -

Cellphone -

Email

Physical address while in South Africa

Suite/Unit number | Complex name

Street number | Street name

Suburb | Post code

Please note that this form expires on 31/03/2023. Up to date forms are always available on www.discovery.co.za under Medical Aid > Manage your health plan > Find important documents and certificates.

DHMITC001

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 D D - M M - Y Y Y Y Return date D D - M M - Y Y Y Y

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 D D M M Y Y Y Y

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

Telephone - Practice number

2. Doctor's name

Telephone - Practice number

4. Declaration

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

Signed at (town or city) on D D - M M - Y Y Y Y

Signature of main member

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