

# Request to reverse the payment of a claim that Malcor Medical Aid Scheme received and paid



## Contact details

Tel: 0860 100 698 • PO Box 8012, Greenstone 1616 • www.malcormedicalaid.co.za

## Who we are

The Malcor Medical Aid Scheme (referred to as 'the Scheme'), registration number 1547, is a non-profit organisation, 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). We take care of the administration of your membership for the Scheme.

## 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@malcormedicalaid.co.za](mailto:claimsadjustments@malcormedicalaid.co.za) or fax it to **0860 235 878**.

**When you sign this application, 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"/>
Passport number	<input type="text"/>			Membership number	<input type="text"/>
Telephone (H)	<input type="text"/>			(W)	<input type="text"/>
Cellphone	<input type="text"/>			Fax	<input type="text"/>
Email	<input type="text"/>				

### 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	<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	<input type="text"/>
Amount that the Scheme paid	<input type="text"/>

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

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

### 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. Please be aware that, in the event of an instruction to reverse a dental claim, a copy of this document will be forwarded to the Dental Mediation Services.
5. The Scheme reserves its right to decline an instruction to reverse a payment if the request is not justified or is for reasons that may be anti-selective towards the Scheme. Should the Scheme decline your instruction to reverse a payment you may query this decision by using the Scheme's internal complaints process as detailed on our website.
6. The Scheme will not be held responsible for any liability and/or consequences that may arise from the reversal of the claim. You agree that you, as the member, take full responsibility for any dispute/liability that may arise with the affected provider resulting from the reversal of this claim.

Main member's name

Main member's signature

Date

D	D	M	M	Y	Y	Y	Y
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