BANKMED NAMIBIA
EST 1990

ADDITIONAL HOSPITAL BENEFIT COVER
CLAIM SUBMISSION FORM

Very Important: Claim must be submitted within 4 months from the date of service.

COMPLETE IN CAPITAL LETTERS

PRINCIPAL MEMBER DETAILS:

FULL NAME	
MEMBERSHIP NUMBER	
DATE OF BIRTH	
POSTAL ADDRESS	
TELEPHONE NO. (WORK)	
TELEPHONE NO. (HOME)	

PATIENT DETAILS:

FULL NAME	
DATE OF BIRTH	

CLAIM DETAILS: (Please attach claim to this form)

NAME OF DOCTOR	
PRACTICE NUMBER	
DATE OF SERVICE	

Note: If you are submitting more than one claim, please use back page for more claim details.

HOSPITALISATION DETAILS:

NAME OF HOSPITAL	
DATE ADMITTED	
DATE DISCHARGED	

MEMBER / PATIENT SIGNATURE:________________________ DATE:_________________

(For Office Use Only)

CLAIM RECEIVED BY: *(PRINT NAME & SIGNATURE)*	
DATE RECEIVED:	

CLAIM DETAILS: (Please attach claim to this form)

NAME OF DOCTOR	
PRACTICE NUMBER	
DATE OF SERVICE	

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PRACTICE NUMBER	
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