ADDITIONAL HOSPITAL BENEFITS COVER CLAIM SUBMISSION FORM

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

COMPLETE IN CAPITAL LETTERS

NMC
NAMIBIA MEDICAL CARE

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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Name of Doctor	
Practice Number	
Date of Service	

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