CLAIM FORM

GapCover®
medical shortfall solutions

Email: claims@insuremed.co.za / Fax: 0865 846 343

A PRINCIPAL MEMBER DETAILS

Title: | Initials: | Surname:

ID/Passport No: | Policy No: G A P

Medical Scheme: | Option:

Membership No:

B CLAIM DETAILS

Practice Name	Practice No.	Service Date	Patient Name	Unpaid Amount

All GapCover and/or CoPay claims must be accompanied by the following documents:

1 Copy of the hospital account. (Please contact the hospital for a copy.)

2 [illegible]

3 [illegible]

4 [illegible]

5 [illegible]

[illegible]

C BANKING DETAILS (Claim Refunds)

Account Holder:

Name of Bank: | Branch Code:

Account No: | Account type:

Contact No/s: H | W | C

The administrator does not accept responsibility for payments made to incorrect bank details provided above.

Date: D D M M Y Y Y Y

Signature of Account Holder: