SES

Lusaka PO Box 30337, Lusaka, Zambia | Office 2, Sandy's Creations, Kafue Road, Lusaka
tel +260 977 770 302 | 24/7 Contact Number **737**
Kitwe PO Box 20324, Kitwe, Zambia | No 33 Freedom Ave, Parklands, Kitwe | tel +260 212 227 998
Livingstone PO Box 61116, Livingstone, Zambia
assist@ses-zambia.com | www.ses-zambia.com

"Giving healthcare a human *touch*"

Division of unihealth

REIMBURSEMENT CLAIM FORM

1. MEMBER INFORMATION

IMPORTANT INFORMATION

- Please return this form with the necessary documentation (e.g. receipts/ invoices/ medication prescription) to claims@ses-zambia.com
- It is your responsibility to retain any original supporting documentation (e.g receipts/ invoices) where copies are submitted to us, as we reserve the right to request original supporting documentation/ receipts up to 12 months after claims settlement for fraud detection purposes.
- Please note that claims payment can be delayed if all sections of the claim form are not completed in full.

MEMBERSHIP NUMBER | GROUP NAME: (if applicable) | ENDORSEMENTS?

ZA [ ] [ ] YES [ ] NO [ ]

TITLE [ ] *Please complete the application in BLOCK CAPITALS

SURNAME: [ ]

FIRST NAME: [ ]

DATE OF BIRTH: D [ ] M [ ] Y [ ] AGE: [ ] GENDER: MALE [ ] FEMALE [ ]

MOBILE: [ ] TELEPHONE: [ ]

EMAIL: [ ]

2. MEDICAL DETAILS

PLEASE SELECT THE TYPE OF TREATMENT RECEIVED:

ELECTIVE [ ] **EMERGENCY** [ ] **FOLLOW-UP** [ ] **DENTAL** [ ]
WELLNESS [ ]

SES

unihealth

"Giving healthcare a human touch"

Division of unihealth

REIMBURSEMENT CLAIM FORM

2. MEDICAL DETAILS

Please provide full details of the symptoms/medical condition that required treatment:

DATE OF TREATMENT D M Y

In what country did the treatment take place?

Please provide full details of the treatment received:

Please provide full details of medication received:

PLEASE SELECT THE PROCEDURES DONE BY DOCTOR/ SPECIALIST:

CONSULTATION ☐ **LABORATORY** ☐ **RADIOLOGY** ☐ **PHARMACY** ☐

3. CLAIM DETAILS

- Please complete all parts of the following table with the details of each invoice and receipt. Please include the amount charged and invoice currency.

Description of expense/ treatment:	Providers Name:	Amount Charged:	Invoice Currency:

"Giving healthcare a human touch"

Division of unihealth

REIMBURSEMENT CLAIM FORM

4. PAYMENT DETAILS

Preferred payment method: Bank Transfer ☐ Cheque ☐

Bank Name:

Account Name/Payee:

Account Number:

SWIFT/BIC Code:

IBAN:

Bank Address:

5. DECLARATION

PLEASE READ THIS SECTION CAREFULLY

In order for us to process your claims, we will need to apply for a medical report from any doctor who has attended to you. To apply, we need you to give your consent by signing the declaration below. Personal data collected on you and where appropriate, your family, will be used by Specialty Emergency Services to process your claims and administer your policy.
Medical information will be kept confidential. It will only be disclosed to those involved with your treatment or care, including Hospitals General Practitioners, Physicians, or other health providers, and if applicable, to any person or organization who may be responsible for meeting your treatment expenses.

TO BE COMPLETED BY THE PATIENT/ PARENT

- I confirm that the information I have given on this form is accurate and correct to the best of my knowledge.
- I confirm that I give explicit consent to obtain and process my medical information with respect to my claims.

Patient Name

Signature

Date