1st Floor
Clover Leaf Building
82 Mutare Road, Msasa
Harare, Zimbabwe
Tel: +263 (242) 487 585
+263 (242) 487 713
+263 (242) 446 194-6
Mobile: +263 772 341 776
info@investmedhealth.co.zw

MEDICAL SERVICES CLAIM FORM

Instructions:

1. Please complete every section below in full and if not applicable, please write N/A.
2. Payments of Claims will be delayed by incomplete or illegible information.
3. This Claim Form must be submitted to Investmed Health Fund within 90 days of receiving treatment/ services.
4. Please enclose ALL original Service Provider reports and letters, invoices, receipts and other supporting documention.
5. This Claim Form must be completed and signed by both the Member ***(Section 1 and 2)*** and the Service Provider ***(Section 3, 4 and 5)***.

Section 1: Principal Member Details

Title | Member Number

First Name

Surname

Identity Number | Date of Birth | Gender

Physical Address

Postal Address

Cellphone | Telephone-Home | Telephone-Work

Email

Section 2: Details Of Person Receiving Medical Services

Title | Member Number

Full Name

Relationship to Principal Member | Date of Receiving Medical Services

Identity Number | Date of Birth | Gender

Physical Address

Postal Address

Cellphone | Telephone-Home | Telephone-Work

Email

Medical Diagnosis

Pre-Authorisation obtained **Yes** ☐ **No** ☐

Member or Patient declaration:

1. I acknowledge that, signing this Claim Form for any treatment which has not been provided is tantamount to committing an offence. I pledge to contact the Fund should I become aware of the adversity of the Claim submitted.
2. I pledge to provide the Fund with the necessary supporting documentation alongside this Claim.
3. I confirm that the details given above are correct, that the amount claimed herein is not claimable from another source and that the Patient is a member of Investmed Health Fund.
4. I hereby authorise the Service Provider to disclose the nature of illness to the Fund for its confidential use, and I agree that no awards will be made for this treatment unless premiums are received in respect of the treatment period.

Signature of Member _____ **Date** ___ ___ _____

Section 3: Details Of The Service Provider

Name of Service Provider

Ahfoz Number | Date Of Providing Medical Services

HPAZ Practice Number

Name of Health Practitioner

Physical Address

Cellphone | Telephone

Email

Section 4: Claim Details

Name of Patient | Member Number

Identity Number | Age | Gender

Date Of Providing Medical Services/ Admission | Date of discharge

Type of Service/ Admission: Emergency ☐ Regular ☐ Elective ☐

Primary Diagnosis | ICD10 Code

Additional Diagnosis | ICD10 Code

Co-Morbidity(ies) | ICD10 Code

Procedure Details

Name Of Referring Doctor (If Any)

For internal use only

Item or Procedure Description	ZRVS/ AHFOZ tarrif code	Qty	Date of claim	Fees charged	Claim Awarded	Comments by Claims Adjudicator
			Total			

Section 5: Service Provider Banking Details

Please provide your full banking details below for claims payments

Name of Account Holder			
Bank Name			
Branch Name		Branch Code	
Account Number		Account Type	

Declaration by the Service Provider:

1. I hereby certify that, I together with my members of staff, have rendered the above stated services to or on behalf of the said Patient.
2. I can confirm that, to the best of my knowledge, the Patient treated is the patient named on this form.
3. I acknowledge that, any Claim for services not rendered by ourselves would be regarded as fraudulent and may be subjected to further investigation and possible prosecution.

Service Provider Signature_____ **Date** ___ ___ _____