2020

TRAUMA COUNSELLING CLAIM FORM

Stratum Benefits Gap Cover

1. YOUR PROFILE

PRINCIPAL INSURED DETAILS

Title | Name

Surname | ID/Passport

Medical Aid | Medical Aid No.

Medical Aid Option

Cellphone | Alternative Contact No.

Email Address

PATIENT DETAILS

◯ Please indicate whether the Patient is the Principal Insured, in which case the below details are not required.

Title | Name

Surname | ID/Passport

Medical Aid | Medical Aid No.

Medical Aid Option

2. TRAUMA EVENT & CONSULTATION DETAILS (To be completed by your treating Healthcare Provider)

The qualifying criteria for our ***TRAUMA COUNSELLING COVER*** *are based on the below listed events. Please indicate the reason for trauma counselling.*

◯ My patient has witnessed/is directly affected by an act of physical violence or an accident.

◯ My patient mourns the death of a loved one.

◯ My patient received word of a loved one's/their own diagnosis of a critical illness.

◯ Other

Consultation Date

3. HEALTHCARE PROVIDER DECLARATION

As the Healthcare Provider who is treating/treated the patient in question, I hereby declare that the information provided is accurate and true.

Healthcare Provider Name

Practice Number

Practice Stamp / Healthcare Provider Signature

4. YOUR CLAIM REIMBURSEMENT PROFILE

The bank account details that you provide in this section will be the bank account details that we use for claim payments. We do not accept any responsibility and/or liability if claim payments are made into an incorrect bank account number that you have provided.

We reserve the right to negotiate a discount with your Healthcare Provider(s) on your behalf to help maintain a favourable risk profile. If your Healthcare Provider(s) agrees to a discount, only then will we pay them directly.

Bank | Account Number

Account Holder

Account Type

◯ Cheque ◯ Savings

Account Holder Signature

AUTHORISATION & DECLARATION ACCEPTANCE

I hereby authorise my medical aid and any Healthcare Provider whom attended to me or any of my dependants to furnish Stratum Benefits (Pty) Ltd and / or their authorised representatives with information required for the assessment of my claim. I declare that the details and supporting documents provided are true and correct. I understand that any non-disclosure or false representation may result in the rejection of this claim and / or cancellation of cover.

Principal Insured Signature

Date

Stratum Benefits (Pty) Ltd, an authorised FSP 2111, is underwritten by Constantia Insurance Company Limited, an authorised FSP 31111.

t 086 111 3499 w www.stratumbenefits.co.za