PARKSMED HEALTH FUND

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Your Health, Our Joint Responsibility

A member of Zimbabwe Parks & Wildlife Management Authority

MEMBERSHIP NUMBER

P	M	0	0	0				

MEDICAL REFUND CLAIM FORM

1. PACKAGE (PLEASE INDICATE BY TICKING THE APPROPRIATE BOX)

BUFFALO ☐ RHINO ☐ ELEPHANT ☐

2. MEMBER'S DETAILS (PLEASE COMPLETE IN BLOCK LETTERS)

Full name of applicant (as appears on slip)	Mr/Mrs/Miss	First name	Surname

3. DETAILS OF CLAIM

NAMES OF BENEFICIARIES	AGE	RELATIONSHIP TO MEMBER	SUFFIX

DETAILS OF CLAIM

DATE	SERVICE PROVIDER	PATIENT`S NAME	TYPE OF TREATMENT/ SERVICE	AMOUNT CLAIMED
TOTAL				

I.....hereby request for assistance of $..... for hospital expenses. Please find attached Proforma invoices/Quotation.

I---------- hereby undertake to provide the receipts soon after receiving service. Failure to provide receipts will result in the funds being deducted from my salary with effect from end of this month.

Signed :..... Date.....

Eligible/Not Eligible..... Date:.....,..

CLAIMS CLERK

Checked by:..... Date:.....,..

CLAIMS ASSESSOR

Recommended/ Not recommended by:..... Date:.....

MEMBERSHIP AND CLAIMS EXECUTIVE

Approved/ Not Approved ..... Date:.....

GENERAL MANAGER

Official Use

Date: _____ Approved/Not Approved:_____

FORM NUMBER 002