Medical Aid Society of Malawi

P.O. Box 1254, BLANTYRE, MALAWI, Telephone: 01 820 298/543 FAX: 01 820 217
E-mail: management@masm.mw
Web: www.masm.mw

PASTE LABEL HERE

DATE STAMP

MEDICAL AID CLAIM FORM

SECTION IN RED TO BE COMPLETED BY MEMBER/PATIENT

SECTION IN BLACK TO BE COMPLETED BY DOCTOR
SHADED SECTIONS FOR USE BY SOCIETY

PRINCIPLE MEMBER _____

POSTAL ADDRESS _____

PHONE # _____ E-MAIL: _____

NAME OF EMPLOYER _____

SCHEME TYPE _____ MEMBER'S No. _____

IF THIS TREATMENT IS DUE TO AN ACCIDENT PLEASE PUT "X" IN THE CORRECT BOX BELOW.

- ☐ ROAD TRAFFIC ACCIDENT
- ☐ ACCIDENT AT WORK
- ☐ ACCIDENT AT HOME
- ☐ OTHER SPECIFY

PATIENT'S NAME	RELATIONSHIP TO MEMBER	PATIENT'S DATE OF BIRTH

SIGNATURE – BEFORE PLEASE NOTE:

1. IF YOU SIGN THIS CLAIM FOR ANY TREATMENT WHICH HAS NOT BEEN PROVIDED YOU MAY WELL BE COMMITTING AN OFFENCE IF YOU BECOME AWARE THAT THE CLAIM IS SUBMITTED FOR SERVICES WHICH HAVE NOT BEEN PROVIDED YOU MUST CONTACT MASM

2. IF THIS TREATMENT HAS NOT BEEN PAID FOR THEN YOU MUST EITHER SIGN EACH DAY THE TREATMENT IS RECEIVED OR ONCE ONLY AFTER THE PROVIDER OF SERVICES HAS INSERTED ALL HIS CHARGES.

3. CLAIM FORMS WHICH ARE SIGNED BEFORE THE DAY ON WHICH THE TREATMENT IS TO BE RECEIVED WILL BE REJECTED.

4. IF TREATMENT HAS BEEN PAID FOR, YOU SHOULD SIGN THE FORM ONCE ONLY BEFORE SENDING IT TO THE MASM. ATTACH YOUR RECEIPT AND INSERT THE AMOUNT YOU ARE CLAIMING IN THE APPROPRIATE BOX ALONGSIDE YOUR SIGNATURE.

SIGNATURE	DATE	FEE CHARGED (IF KNOWN)

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 OR DEPENDANT OF THE SOCIETY, I AUTHORISE THE PROVIDER OF SERVICES TO DISCLOSE THE NATURE OF ILLNESS TO MASM FOR ITS CONFIDENTIAL USE AND I AGREE THAT NO AWARDS WILL BE MADE FOR THIS TREATMENT UNLESS CONTRIBUTIONS ARE RECEIVED IN RESPECT OF THE PERIOD OF TREATMENT.

DOCTOR'S No.	INVOICE No.	DATE CLAIM CLOSED	REF. DOC No.

LINE		TARIFF CODE/ DESCRIPTION	QNTY.	YR	MTH	DAYS	FEE CHARGED		AWARD		SHORTFALL		REASON	PATIENT'S SIGNATURE
01														
02														
03														
04														
05														
06														
07														
08														
09														
10														
11														
12														
13														
14														
15														
16														
MEDICAL AID MEMBERS CLAIM THIS AMOUNT →									← **TOTAL DEBIT THIS A/C**					

I hereby certify that I or members of my staff have rendered the services to or on behalf of the patient. I confirm that to the best of my knowledge the patient treated is the patient named on this form. I agree that any claim for services not provided would be regarded as fraudulent and tender the people liable to prosecution.

DIAGNOSIS _____

(Doctors) Signature _____
and Official Stamp of provider of services

Date: _____

☐ If there are any other matters you wish to bring to the Society, tick this box and make your comments overleaf.