



Contact us

Tel: 0860 123 077 • PO Box 652509, Benmore 2010 • www.tfgmedicalaidscheme.co.za

Request to reverse the payment of a claim that TFG Medical Aid Scheme received and paid

This form is to ask TFG Medical Aid Scheme (referred to as 'the Scheme'), to reverse a payment that we made to you or to a healthcare provider.

Who we are

TFG Medical Aid Scheme (referred to as 'the Scheme'), registration number 1578, is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Scheme.

How to complete this form

- 1. Please use one letter per block, complete in black ink and print clearly.
- 2. Please ensure the main member signs and dates the form.
- 3. Once complete, please fax your form to 0860 235 878 or email it to claimsadjustments@discovery.co.za

When you sign this application, you confirm that you have read and understood the requirements and that the information is true and complete.

1. About the main member																	
Title Initials Surname																	
Identity number								Da	ate o	f bir	th [Υ	Υ	Υ	I M	M D) D
Passport number	Membership number																
Telephone (H)													L				
Cellphone							Fa	ax					L				
Email																	
2. About the claim that you want the Scheme																	
Details of the claim that the Scheme paid and that you war	nt revers	ed:															
Service date				Pra	actice	numb	er 🗌										
Practice name or name of healthcare provider																	
Claim reference number (if available)																	
Healthcare service																	
Amount claimed		Amo	unt th	at the	Scher	ne pa	id										
Please give a brief explanation of why you want the payme	ent for th	is healtl	ncare :	service	rever	sed											

3. Important information about your request to reverse payment of a claim

- 1. Please be aware that when we reverse the payment we made for this healthcare service, the healthcare provider may still hold you responsible for the payment of this amount.
- 2. You agree that when the Scheme reverses the payment we made to you or to the provider, we will not process or pay this claim again.
- 3. You agree that we let the healthcare provider know of your request to have this payment reversed. We may also give this confirmation to the healthcare provider in writing.

Main member's name															I							
Main member's signature	L				 		 						D	ate	Υ	Υ	Υ	Υ	M	М	D	D

Please do not sign an incomplete application form