Medical Aid Scheme

Administered by Discovery Health

Contact details
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 or passport number ____

Date of birth Y Y Y Y M M D D

Membership number ____

Telephone (H) ____ Telephone (W) ____

Cellphone ____

Email ____

2. About the claim that you want the Scheme to reverse

Details of the claim that the Scheme paid and that you want reversed:

Service date Y Y Y Y M M D D Practice number ____

Practice name or name of healthcare provider ____

Healthcare service ____

Amount Claimed ____ Amount that the Scheme paid ____

Please give a brief explanation of why you want us to reverse this payment

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TFGRRP001

Please note that this form expires on 31/03/2025. Up to date forms are available on www.tfgmedicalaidscheme.co.za.
Alternatively members can phone 0860 123 077 and health professionals can phone 0860 44 55 66.

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.
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.
4. Any misrepresentation of the reason/s for the reversal/s could lead to the termination of your membership.

Main member's name

Main member's signature

Date Y Y Y Y M M D D

Please do not sign an incomplete application form