

CLAIMS PROCEDURE

- (1) Claims in respect of a relevant health service may be submitted to the Scheme electronically.
- (2) A claim bearing the ICD10 diagnostic code and/or any other legitimate claim submitted to the Scheme electronically shall be paid to the provider of the relevant health service directly in accordance with the relevant benefit schedule of Annexure B, limited to the LAHR OR LAMR or to the cost in terms of any contract agreement or arrangement between the Scheme and the supplier, as the case may be.
- (3) For the purpose of expediting settlement of claims relating to the chronic disease list of the prescribed minimum benefits, the ICD10 diagnostic code that relates to the relevant health service must be reflected on the claim: Provided that any other coding recognizable by the Scheme's systems will also be accepted .
- (4) In respect of a claim relating to the prescribed minimum benefits other than that in the chronic disease list, diagnosis information by description or coding must be reflected on the claim. Otherwise the claim will be treated like that for ordinary benefits.
- (5) Where the Scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, the Scheme shall notify the member and the health care provider accordingly within 30 days after receipt thereof. The Scheme shall state the reasons why such claim is erroneous or unacceptable and afford such member and provider the opportunity to return such corrected claim to the Scheme within sixty days of the notice.

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REGISTRAR OF MEDICAL SCHEMES

- 1 -

(6) On receipt by a member of an account in respect of medical expenses, he shall forthwith submit to the Scheme such account duly certified by him as being a true and correct statement of the expenses so incurred by him or his dependants.

(7) A member shall ensure that any account forwarded by him to the Scheme shall embody –

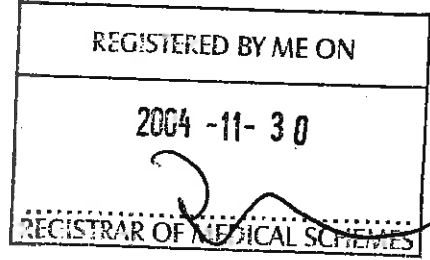
(a) the name and membership number of such member;

(b) the name of the patient;

(c) the date and nature of the service rendered;

(d) the cost of the service rendered; and

(e) the name and qualifications of the provider of any relevant health service by whom the service was rendered.



(8) Subject to the provisions of paragraph (10) –

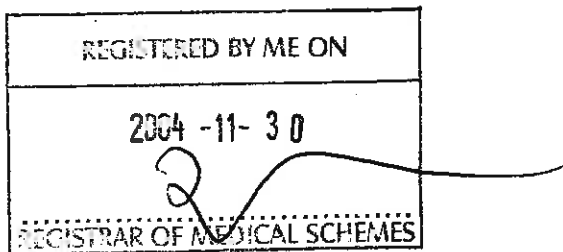
(a) the documents specified in paragraph (6) must be submitted to the Scheme on or before the last day of the fourth month following the date on which the service in respect whereof the claim is being made was rendered; and

(b) any request by a member for payment of benefits payable in respect of an account fully settled by him shall be accompanied by an account duly certified as correct and fully specified in terms of paragraph (7) and the receipt for payment thereof, and must be submitted to the Scheme on or before the last day of the fourth month following the date on which the service in respect whereof the claim in being made, was rendered.

Also provided for in (5)

(c) A corrected account claim or statement must be resubmitted to the Scheme within 60 days following the date on which it is returned for correction.

- (9) Should the documents specified in paragraph (8)(a), (b) or (c) not reach the Scheme before the last day contemplated by paragraph (8)(a) or (c), but subject to the provisions of paragraph (10), no benefits shall be payable and the documents shall be returned to the member concerned.
- (10) (a) On receipt of an account which has not been fully settled by a member, the Scheme shall pay the benefit in respect of such account, as determined in the Benefit Schedules of these Rules.
- (b) Any portion of an account in excess of the applicable benefit and which is not payable by the Scheme shall remain the personal liability of the member concerned.
- (11) On receipt of an account which has been fully settled by a member the Scheme shall pay to the member an amount equal to the amount which would have been payable had such account not been fully settled by such member.



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