LIBERTY

Invoice number

HEALTH COVER
Claim Form

Important: please read the following before completing this claim form.
This form must be completed for every patient receiving treatment. Please complete a separate claim form for each visit and attached your invoice for processing. The patient should be given a duplicate copy for their record. Please attached detailed invoice where possible to expedite payment. Please write clearly using capital and block letters. **Note:** Liberty Health will reject illegible or incomplate claims.

PATIENT DETAILS

FIRST NAME | SURNAME

MEMBER NO. | DEP CODE | GENDER M F | DOB D D M M C C Y Y

MAIN MEMBER DETAILS

FIRST NAME | SURNAME

EMPLOYER

SERVICE PROVIDER DETAILS

NAME OF CLINIC | CONSULTING PHYSICIAN

LIBERTY HEALTH PROVIDER NO | TREATMENT DATE D D M M C C Y Y

SHOULD HOSPITALISATION HAVE BEEN REQUIRED PLEASE INDICATE DURATION OF STAY

ADMISSION DATE D D M M C C Y Y | DISCHARGE DATE D D M M C C Y Y

PLEASE REFER TO LIBERTY HEALTH DIAGNOSIS CODING

DIAGNOSIS	CODE (TICK)	DIAGNOSIS	CODE (TICK)	DIAGNOSIS	CODE (TICK)	DIAGNOSIS	CODE (TICK)
ALLERGIC RHINITIS	J30	C-SECTION	O82	MALARIA	B54	PHARYNGITIS	J02
ANAEMIA	D64	DENTAL CARIES	K02	MYOPIA	H52	PNEUMONIA	J18
ANTENATAL SCREENING	Z36	DERMATITIS	L30	OPTICAL EXAMINATION OF EYES AND VISION	Z01	SPONTANEOUS BIRTH	O80
BRONCHITIS	J40	DIARRHOEA/GASTRO	A09			TONSILLITIS	J03
CANDIDIASIS	B37	GASTRITIS	K29	OTITUS MEDIA	H66	URTI	J06
CONJUNCTIVITIS	H10	INFLUENZA	J10	PEPTIC ULCER	K27	UTI	N39
OTHER							

CONSULTATION	0190 GP	0191 SPECIALIST	11001 OPTICAL	8101 DENTAL	OTHER	COST	
IS THIS A MATERNITY RELATED CLAIM?				Yes	No		

SERVICE PROVIDED	CODE	DESCRIPTION	COST
LABORATORY TESTS			
OTHER DIAGNOSTIC PROCEDURES/TESTS			
OPTICAL			
DENTAL			

PRESCRIBED DRUGS (ATTACH COPY OF PRESCRIPTION)	CODE	QTY	DOSAGE	DESCRIPTION	

TOTAL MEDICAL COSTS (INDICATE CURRENCY)

PROVIDER'S DECLARATION

I CERTIFY THAT THE ABOVE PATIENT HAS RECEIVED THE SERVICES & TREATMENT NOTED ON THIS FORM, DIAGNOSED AND ADMINISTERED BY MYSELF AND THAT THIS CLAIM IS IN ACCORDANCE WITH MY SPECIFIED TREATMENT.

PROVIDER STAMP

SIGNED | **DATE** D D M M C C Y Y

PATIENT'S DECLARATION

I HEREBY DECLARE THE ABOVE STATED TO BE TRUE AND IN ACCORDANCE WITH THE MEDICAL SCHEME RULES. 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 ON BLUE HEALTH INSURANCE. I AUTHORISE THE PROVIDER OF SERVICES TO DISCLOSE THE NATURE OF ILLNESS TO BLUE 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. LIBERTY HEALTH RESERVES THE RIGHT TO RECOVER ANY AMOUNTS PAID TO PROVIDERS IN EXCESS OF BENEFITS DIRECTLY .

SIGNED | **DATE** D D M M C C Y Y