REIMBURSEMENT FORM

DATE:.. *Roding ID No*... *STAFF ID No (if any)* ....

INSTRUCTIONS: THANK YOU FOR OPPORTUNITY TO SERVE. PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY BEFORE COMPLETING THE FORM:

- **You may refer to the reimbursement section of our user manual before completing this form**
- **Please note that your claim will only be processed, if your claim is approved by the Quality Assurance Team after due diligence and proper investigation.**
- **Authenticated claims which comply to the terms and conditions of treatment within the benefit cover of the client would be vetted with our generic (operational) tariff and paid within 30 working days of our receiving the completed application.**
- **Your claims may be declined if due process was not followed.**
- **You may delay or forfeit a reimbursement by either not giving proper information; non compliance with ROHL modus operandi; going beyond the package benefit cover or not informing ROHL within 48 hours for proper and prompt verification by the Quality Assurance department.**
- **Please complete the client section of this form in order to be assured of processing within 30 working days.**
- **All the fields under the client section are compulsory.**
- **Submission of duplicate and scanned copies of applicable documents as opposed to original copies may delay payment.**
- **Incomplete forms will not be processed.**
- **You may be asked to present more documents apart from the ones submitted in order to verify your request.**
- **A medical report must accompany all cases of surgery , admission, procedures and special /advanced investigations**
- **We may seek for part reimbursement from other packages or plans you are registered under; which covers same benefits you are requesting payment for after due settlement.**
- **It is a crime to request for a reimbursement with the intent to defraud any individual or organization.Any information or material fact concealed or altered with the intent to mislead us may be reported to your Human Resource Department(if applicable) or other appropriate authorities if uncovered.**
- **The form must be fully completed and signed. Roding Healthcare will not take responsibility for non payment of claims due to incomplete information and/or documentation.**
- **If the applicant is under 18 years of age this declaration must be signed by their parent or legal guardian.**

NAME OF MEMBER APPLYING FOR REIMBURSEMENT:____

(Full names in block letters with surname first)

NAME OF THE ORGANIZATION:

____

*REASON FOR APPLYING FOR REIMBURSEMENT:*____

____

*NAME OF BANK*____ *ACCOUNT NO.*____

AMOUNT FOR REIMBURSEMENT (in words):

RODING HEALTHCARE LTD

REIMBURSEMENT FORM

AMOUNT FOR REIMBURSEMENT: (in figures):____

NAME OF ATTACHED DOCUMENT(S) IN SUPPORT OF THE REIMBURSEMENT (Please the tick the applicable documents):

Payment Receipt

Original copy ☐ Duplicate copy ☐ Scanned copy ☐

Medical report

Original copy ☐ Duplicate copy ☐ Scanned copy ☐

Cost detail breakdown Analysis

Original copy ☐ Duplicate copy ☐ Scanned copy ☐

Result of the investigations or laboratory test

Original copy ☐ Duplicate copy ☐ Scanned copy ☐

Prescription

Original copy ☐ Duplicate copy ☐ Scanned copy ☐

Others(Please give details)____

Have you received any treatment/clinical evaluation in the facility(hospital, clinic or diagnostic centre) in question before? Yes ☐ No ☐

If yes, when (date):______________________ Why?________________________________

____(Brief Description or Diagnosis if known)

Are you under any other plan or package which covers the requested refund benefit either directly, as a spouse or dependant? Yes ☐ No ☐ if yes what is name of the company giving the Cover:____

I hereby give permission to Roding Healthcare, Its consultants, agents or appointed third party administrators to have access to any of my medical records. I declare that any false statement above or non-disclosure of any material fact will render the reimbursement null and void. I understand that refunds will be made on payment of the appropriate subscription fees by you or your organization and that the above stated instructions have been read and fully understood by me.

Signature ______________________ **Date** ______/_____/________

REIMBURSEMENT FORM

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OFFICE USE ONLY

NAME OF CLIENT SERVICE STAFF /OTHER STAFF RECEIVING THE APPLICATION:

___

SIGNATURE /DATE: ______________________________

CLIENT SERVICE/ENROLLMENT

COMMENT:

___

DESIGNATION: ……………………………………………………… ***SIGNATURE/DATE :***………………………………………………………

QUALITY ASSURANCE /MEDICALS/NETWORK

COMMENT :

___

DESIGNATION:…………………………………………………………………… ***SIGNATURE/DATE:***……………………………………………………………………

REIMBURSEMENT FORM

AUTHORIZED SIGNATORY/MANAGING DIRECTOR

COMMENT/APPROVED:

SIGNATURE/DATE:____

CLAIMS/ACCOUNTS

COMMENT:

____

SUM APPLIED FOR	*SUM ACTUALLY REFUNDED*	*REASON FOR REDUCTION IN REFUND(LESS THAN AMOUNT APPLIED FOR {if applicable})*

DESIGNATION:... ***SIGNATURE/DATE:***...