



Claim Form (Confidential)

Office Use Only

Med No	P.C
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Kindly complete all the fields below and attach all relevant documents in originals. Also ensure that the claim is submitted within a delay of 3 months from the date of treatment. Claims refund might be delayed and/ or declined if the above is not attended to.
(Kindly use ONE CLAIM FORM per patient and per illness.)

MEMBER DETAILS

Main Member First Name	
Main Member Family Name	
Membership Number	
Company Name	

Patient First Name	
Patient Family Name	

CLAIM DETAILS

(1) Nature of Illness, Injury, Surgery:
(2) If part of the treatment has already been claimed for, please provide the date and / or reference of the previous claim:
(3) If the claim is made in relation to an accident, please provide details of all parties involved on a different sheet.
(4) Total Amount Being Claimed (MUR):

DOCUMENT CHECKLIST

HAVE YOU ENCLOSED?

- Doctor's Certificate regarding Nature of Illness
- Original Receipts and Prescriptions
- Detailed Pharmacy Bills
- Detailed Laboratory Receipts
- Notation and Surface of Teeth Treated where relevant
- Details of Lenses for Optical Claims
- In case of Accident, separate sheet detailing all parties involved

DECLARATION

I hereby declare that the above statements are true and that I have not withheld any information connected with this claim. I hereby authorise any medical practitioner (GP & Specialist) and any Health Service Provider (Public & Private) to disclose to Medscheme (Mtius) Ltd any information pertaining to this claim.

Member Signature: _____

Date:

Please submit your claim documents to:
Medscheme (Mtius) Limited, 1st Floor, Tower A, 1Cybercity, Ebene.
Customer Hotline: 403 5073 Fax: 403 5088
Email: mosante@businessmauritius.org

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