westerngap

shortfall cover

Claim Form

IMPORTANT NOTE: Complete, sign and return the Claim form to western@kaelo.co.za

In order for a Claim to be valid, there are certain basic criteria that have to be met. These include, but are not limited to:

- Your premiums being paid up;
- You being a member of a valid South African Medical Scheme;
- You having been hospitalised (certain procedures such as an Endoscopic procedure, CT Scan and Chemotherapy does not require hospitalisation - Please refer to your Policy for the listed outpatient procedures that are covered);
- Your procedure not involving drug/alcohol rehabilitation or admission for depression or dental implants (please refer to the Policy for a full list of exclusions);
- Having obtained an authorisation number for the procedure from your Medical Scheme;
- Your Specialist, i.e. your surgeon or your anaesthetist, having charged a higher rate than your Medical Scheme reimbursement rate, i.e. you having a shortfall;
- Your Medical Scheme option requiring you to pay a Co-Payment or upfront Deductible (If a Benefit is provided), not related to the use of providers or authorisation/referral processes (unless a Benefit is provided);
- You receiving Accidental Emergency Treatment (as defined in the Policy) in a hospital casualty ward, and your Medical Scheme not covering this from the In-Hospital risk portion of your Medical Scheme;
- You having exceeded your limit for Oncology Treatment;
- Your Medical Scheme option requiring you to pay a Co-Payment for Oncology Treatment.
- You spend three days or more in a stepdown or recovery facility following a severe hospitalisation event;
- The main member suffered a death, accidental death or total and permanent disability.

1. Once you have established that you have a valid Claim, you will be required to complete this Claim form. Please note that this is not an automatic process, and you will be required to submit a separate Claim form to the Claim that has been submitted to your Medical Scheme.

2. When submitting the Claim form, you will also need to provide a copy of the relevant Specialists' accounts, Hospital accounts and Medical Scheme statement showing the processing of the accounts and the shortfall. Please note that the Claim will not be processed until all documents have been received.

   You have six months from the first day that you were hospitalised to submit your Claim and relevant documentation.

3. Any Claim received for the first time after the six month period has expired, will not be honoured. Should a portion of the documentation be received within the six month period, the Claim will be held pending for a further six month period, after which it will go stale and will not be honoured.

4. Processing of insurance information is done in accordance with applicable legislation, as well as our Privacy Policy which can be found in our Compliance and Trust Centre on our website: www.kaelo.co.za

5. Claims are assessed on a line by line basis. Each line has a code on your healthcare or service provider's account and this accounts for the total amount charged.

   These codes describe the medical procedure that was performed or the service that was provided.
   Your medical aid must pay a portion of the cost of a coded line from your hospital or risk benefit in order for that claim line shortfall to be covered by your Gap cover unless you are claiming for a benefit with different qualifying criteria such as a Family protector or a defined co-payment.

6. PMB Claims

   Claims flagged as Prescribed Minimum Benefit (PMB) medical procedures or claims with a high values may be investigated with your medical Scheme or discussed with your service provider. PMBs are a set of defined benefits that medical Schemes are required to cover by law. This means that as a medical aid member, you shouldn't incur any out-of-pocket medical expenses related to a PMB.

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Please note that if you are a VAT registered vendor, this insurance claim settlement could potentially create a liability to pay output VAT to SARS i.t.o. S8 (8) of the VAT Act.
Please direct all queries to the Kaelo Service Centre on **0861 008 258**.
Claims can be e-mailed to **western@kaelo.co.za.**

Once received, your Claim will be processed and if all requirements have been met, the Benefit amount will be paid within seven to 14 working days.

Claims Checklist / Upload

Please note that your Claim cannot be assessed until you have submitted all the relevant documentation.

In order for us to assess your Claim without any delays, please ensure you have the following documents:

Tariff Shortfalls, Accidental Casualty, Oncology, Innovative Medicines, Co-Payment, Maternity Booster or Step-down Facility

- ◯ Fully completed Claim Form. Sections A to E and J are mandatory.
- ◯ Detailed Doctors' Accounts where there is a shortfall being claimed. (Request from the Doctor. Please note that a quote is not sufficient.)
- ◯ Detailed Medical Scheme statement including rejection reasons.
- ◯ Detailed Hospital Account or Step down Facility account including admission and discharge dates.
- ◯ Oncology Treatment Plan received from your Medical Scheme which confirms the treatment you are approved for and for which period it is approved. This applies only to Oncology related claims.

Contribution Waiver and Accidental Death and Disability Benefit

- ◯ Fully completed Claim Form. Sections A to D, G and J are mandatory.
- ◯ Copy of Death Certificate.
- ◯ Police Report (If reported to the Police)
- ◯ Disability Report (Attending Doctor to Complete).
- ◯ Medical Scheme Membership Certificate (This must reflect your monthly Medical Scheme contribution amount).
- ◯ Proof of Bank Account.
- ◯ ID of Claimant and Deceased.

Dental Reconstruction Benefit

- ◯ Fully completed Claim Form. Sections A to D, I and J are mandatory.
- ◯ Detailed Doctors' Accounts where there is a shortfall being claimed. (Request from the Doctor. Please note that a quote is not sufficient.)
- ◯ Detailed Medical Scheme statement including rejection reasons.
- ◯ Detailed Hospital Account including admission and discharge dates.
- ◯ A motivation letter from your Dental Surgeon (Accident and Oncology).

Oncology-First Time Diagnosis

- ◯ Fully completed Claim Form. Sections A to D, H and J are mandatory.
- ◯ Medical Reports - From your Oncologist.
- ◯ Histology Reports. This is a report from the pathologist (EG: Lancet Laboratories or Ampath) who conducted your tests, you can obtain this from your Oncologist.
- ◯ Test Results. This refers to all other tests performed in relation to your Oncology diagnosis.
- ◯ Oncology Treatment Plan received from your Medical Scheme which confirms the treatment you are approved for and for which period it is approved. This applies only to Oncology related claims.

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A Policyholder Details:

Title: _____ Initials: _____

Surname: _____ Name: _____

Employer Name: _____ Employment Date: _____

ID Number: _____

Medical Scheme Name: _____ Medical Scheme Plan: _____

Medical Scheme No: _____ Gap Policy No: _____

Cell No: _____ Home No: _____

Work No: _____

Postal Address: _____

_____ Code: _____

E-mail Address: _____

B Payment Instructions:

Payments will only be made to the Policyholder's account.
No payments will be made to credit card accounts.
The company will not be liable for the loss of funds due to the provision of incorrect bank details by the Policyholder.

Bank Name: _____

Account No: _____

Branch Name: _____ Branch Code: _____

Account Holder Name: _____

Account Type: Cheque ◯ Transmission ◯ Savings ◯

Account Holder Signature: _____ Date: _____

C Patient Details:

Title: _____ Initials: _____

Surname: _____ Name: _____

ID Number: _____

Relationship to Policyholder: Self ◯ Spouse ◯ Child ◯ Other: _____

Cell No: _____

E-mail Address: _____

This is not a Medical Scheme and the cover is not the same as that of a Medical Scheme. This Policy is not a substitute for Medical Scheme membership.

Kaelo Risk (Pty) Ltd is an authorised Financial Services Provider (FSP: 36931).
Underwritten by Western National Insurance Company Limited (FAIS: Juristic Representative under FSP no 9465).

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D Event Details:

If you are claiming for the Contribution Waiver, Accidental Death and Disability or Oncology First Time Diagnosis Benefits, please do not complete this section.

Where did the procedure take place: ◯ In-Hospital ◯ Doctors Rooms ◯ Casualty Ward

Was the hospitalisation as a result of an accident?: Yes ◯ No ◯

Hospital/Service Provider Name: _____

Procedure Details/Reason for hospitalisation: _____

Admission/Event Date: | | | | | | | | | Discharge Date: | | | | | | | | |

E Benefit Claimed | Shortfalls, Oncology, Accidental Casualty, Casualty Child Illness or Innovative Medicines:

Please complete this section if you are claiming for Tariff Shortfall, Oncology, Accidental Casualty, Casualty Child Illness or Innovative Medicines Benefits.

Service Date	Doctor's Name	Doctor's Charged Amount	Medical Scheme Paid	Shortfall You Are Claiming

F Benefit Claimed Details | Co-Payment, Maternity Booster or Step-down Facility:

Please complete this section if you are claiming for Co-Payment, Maternity Booster or the Step-down Facility Benefits.

Date	Service Provider	Amount	Benefit type (please tick)					
			Co-payment		Step Down Facility		Maternity Booster	
			Co-payment		Step Down Facility		Maternity Booster	
			Co-payment		Step Down Facility		Maternity Booster	
			Co-payment		Step Down Facility		Maternity Booster	
			Co-payment		Step Down Facility		Maternity Booster	

G Benefit Claimed | Contribution Waiver or Accidental Death and Disability:

Please complete this section if you are claiming for Contribution Waiver or Accidental Death and Disability Benefit.

Select the benefit you are claiming for:

◯ Contribution Waiver: Medical Scheme

◯ Contribution Waiver: Gap Cover

◯ Accidental Death and Disability Benefit: Death

◯ Accidental Death and Disability Benefit: Total and Permanent Disability

Date of Death/Accident: | | | | | | | | | *Please attach a copy of the Death Certificate and Police Report (if an accident)*

Details leading to disability: _____

Medical Scheme Premium: _____ *(Amount in Rands)* *Please attach a copy of the Medical Scheme Membership Certificate*

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H Benefit Claimed | Oncology-First Time Diagnosis

Please complete this section if you are claiming for Oncology-First Time Diagnosis.

Type of Cancer: _____

Diagnosis Date: | | | | | | | | |

Is this a first time cancer diagnosis?: ◯ Yes ◯ No

I Benefit Claimed | Dental Reconstruction:

Please complete this section if you are claiming for the Dental Reconstruction Benefit.

Was the event related to: ◯ Accident ◯ Oncology

Please confirm the date of the accident or treatment: | | | | | | | | |

If this event was related to Oncology Treatment, please confirm the date you were first diagnosed: | | | | | | | | |

Service Date	Provider Name	Practice Number	Amount Claimed	Doctor's Charged Amount	Medical Scheme Paid	Shortfall You Are Claiming

J Declaration:

I hereby declare that the person mentioned under Claimant details is nominated under the abovementioned Policy, that all the particulars given are true and complete, and that the hospitalisation was not wholly or partly, directly or indirectly, caused by the contingencies mentioned in both the General and Specific exceptions attached to the Policy in question. I further declare that the above statements are true and that I have withheld no material information and that I undertake to furnish any documentation which may be required by the Insurance Company or its representatives. I expressly waive all provisions of law, custom or professional etiquette forbidding any physician or other person who attended or examined the Claimant, or any institution in which the Claimant received Treatment, to disclose any knowledge or information which was thereby acquired and agree that this authority shall remain in force until cancelled in writing. I authorise all such persons or agencies to furnish any information in their possession to Kaelo or its representatives.

Kaelo Risk (Pty) Ltd reserves the right to negotiate a discounted rate with the relevant service providers on your behalf, if a discount is granted, payment will be made directly into the respective service provider's/Doctor's bank account thus rendering the Payment Instruction on the Claim Form null and void.

Policyholder Signature: _____ **Date:** | | | | | | | | |

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