# DOCUMENTS FOR CLAIMS SUBMISSION

Please see the following requirements when submitting manual claims:

## GAP COVER CLAIM

1. DOCTOR'S ACCOUNT
2. MEDICAL AID STATEMENT

## SUB LIMIT CLAIM

(for Internal Prostheses, MRI/CT/PET scan, Colonoscopy and Gastroscopy claims only)

1. HOSPITAL ACCOUNT
2. DOCTOR'S ACCOUNT
3. MEDICAL AID STATEMENT
4. MEDICAL AID AUTHORISATION LETTER

## GLOBAL FEE CLAIM

1. HOSPITAL ACCOUNT
2. DOCTOR'S ACCOUNT
3. MEDICAL AID STATEMENT
4. MEDICAL AID AUTHORISATION LETTER

## CO-PAYMENT CLAIM

1. DOCTOR'S ACCOUNT
2. MEDICAL AID STATEMENT
3. MEDICAL AID AUTHORISATION LETTER or First 2 pages of the HOSPITAL ACCOUNT
4. **VERY IMPORTANT - RECEIPT SHOWING PAYMENT TO SERVICE PROVIDER**

## CASUALTY CLAIM

1. DOCTOR'S ACCOUNT (for treatment that occurred in the casualty unit)
2. MEDICAL AID STATEMENT

Policyholders may also make use of the online claims submission facility at: www.claims.totalrisksa.co.za
Please see the examples of these documents provided.
Queries in this regard can be directed to claims@totalrisksa.co.za

16 Jersey Drive, Longmeadow Business Estate (East), Longmeadow, Edenvale, Johannesburg, 1609
P.O. Box 8012, Greenstone, 1616
T 011 372 1540 I F 011 372 1579 I W www.totalrisksa.co.za

TOTAL RISK ADMINISTRATORS (PTY) LTD
an authorised financial services provider

Directors: FRANK THAYER (CEO), GEOFF DU PREEZ (COO)
Reg. No.: 1999/024507/07 I FSP No. 40815

# EXAMPLE OF DOCTORS ACCOUNT

## DR SMITH

| **VAT NUMBER : 1234567**<br>(All amounts on this statement include VAT) | **PRACTICE NUMBER: 1234567** |
|---|---|
| P.O. BOX 11111<br>Aaaaaaaaaa<br>11111<br>RSA | TEL: +27 011 111 1111<br>FAX: 111111111111111<br>e-mail: claims@totalrisksa.co.za |
| Plan | Page 1 |

| Your account No: AAA111 | | | STATEMENT | | 02-07-2018 |
|---|---|---|---|---|---|
| **Mrs Jones**<br>**111 Aaaaaaaa**<br>**PO BOX 11111**<br>**AAAAAAAA**<br>**1111** | | | Med.aid: Xxxxxxxxx<br>Med.aid No: 123456789<br>Patient : Mrs Jones (Female)<br>Birthdate: 11-11-1111 Number: 00<br>Auth Number: 12345<br>Surgeon: Smith (1234567)<br>Anaesthetist: Weston (7654321)<br>Pat. Id-Number: 1111111111111<br>Tel: 1111111111<br>Tel: 1111111111 | | |
| **Date** | | **Code** | **Description** | **Amount** | **Total** |
| 11-05-2018 | [ICD-10: O30.0] | 2615 | Global obstetric care: All-inclusive fee for caesarean section | 12 000.00 | 16 400.00 |
| | Authorization: 12345 | | | | |
| 11-05-2018 | [ICD-10: O30.030.0] | 0011 | Emergency procedures (all hours) | 1 000.00 | |
| | Authorization: 12345 | | | | |
| 11-05-2018 | [ICD-10: O30.0] | 0009 | Assistant Fee | 2 400.00 | |
| | | | | | |
| | Authorization: 12345 | | | | |
| 11-05-2018 | [ICD-10: O30.0] | 0011 | Emergency procedures (all hours) | 1 000.00 | |
| | Authorization: 12345 | | | | |
| 30-05-2018 | Receipt | 0000 | Payment by Medical Aid | 6 060.00 | |
| | | | | | |

SEND PROOF OF PAYMENT TO EMAIL: accounts@name.co.za OR FAX: 011 000 0000; USE DEB19490 AS REFERENCE
PRIVATE RATE - A/C SUBMITTED TO MEDICAL AID, REMAINS YOUR RESPONSIBILITY UNTIL SETTLED
MEDICAL AID MAY PAY YOU. PLEASE SETTLE SOON

| For electronic funds transfer and payment, please use the following bank details: | |
|---|---|
| | Our reference : 123456 |
| Account Name : Smit | Account No : 1111 111 1111 |
| Bank Name : XXXXXX Bank | Branch Code : 111 111 |

| | 120+days | 90 days | 60 days | 30 days | Current | Now Due |
|---|---|---|---|---|---|---|
| **Total Due** | 0.00 | 0.00 | 0.00 | 10 340.00 | 0.00 | 10 340.00 |

EXAMPLE

# EXAMPLE OF
# MEDICAL AID STATEMENT

| Scheme Option | Membership Number | Date of Scheme payment run |
|---|---|---|
| Premium | 123456789 | 30/05/2018 |
| See the end section of the statement for a detailed explanation of statement contents and message code | | |

## CLAIMS

**Provider: Dr Smith Practice Number 1234567**

| Treatment Date | Medical Aid Tariff Code | Claimed Amount | Medical Aid Amount/Rate | Day to Day (Not hospital related) | Scheme Benefit (In-hospital Benefit) | Member Annual Savings Account | Member liable (Scheme has not paid) | Payment due to Provider/Doctor | Payment due to Member/You | Rejection Code/ Information Code |
|---|---|---|---|---|---|---|---|---|---|---|
| 11/05/2018 | 2615 | 12 000.00 | 3 620.00 | 0.00 | 3 620.00 | 0.00 | 8 380.00 | | 3 620.00 | 6 |
| 11/05/2018 | 0011 | 1 000.00 | 470.00 | 0.00 | 470.00 | 0.00 | 530.00 | | 470.00 | 6 |
| 11/05/2018 | 0009 | 2 400.00 | 1 500.00 | 0.00 | 1 500.00 | 0.00 | 900.00 | | 1 500.00 | 6 |
| 11/05/2018 | 0011 | 1 000.00 | 470.00 | 0.00 | 470.00 | 0.00 | 530.00 | | 470.00 | 6 |
| Sub Totals | | 16 400.00 | 6 060.00 | 0.00 | 6 060.00 | 0.00 | 10 340.00 | | 6 060.00 | 6 |

## PLEASE NOTE

6 Practice charges more than Medical Aid Rates. Member liable.

EXAMPLE

# EXAMPLE OF MEDICAL AID AUTHORISATION LETTER

## AUTHORISATION INFORMATION FOR MRS JONES

| | |
|---|---|
| Authorisation number | 123456789 |
| Patient's name: | Mrs Jones |
| Patient's date of birth | 1911/11/11 |
| AAAAAA Membership number | 123456789 |
| Plan | Premium |

## TREATMENT INFORMATION

| | |
|---|---|
| Facility | AAAAAAA Hospital |
| Treating Doctor | Dr Smith 1234567 |
| Date of admission | 2018/05/10 |
| Date of procedure or treatment | 2018/05/11 |
| Length of stay | 3.0 day(s) |

## CODES THE HOSPITAL NEEDS

| **ICD 10 diagnosis codes** | **CCSA treatment codes (hospital codes)*** |
|---|---|
| O30.0<br>P03.4 | 11111<br>22222 |

*These codes are used for information purposes between the hospital and the medical aid

## YOUR TREATMENT(S)

| **Treatment Required** | **Decision made on the request** |
|---|---|
| Global Obstetric Care | Approved |
| Newborn affected by caesarean delivery | Approved |

| | |
|---|---|
| **Co-Payment** | **None** |

EXAMPLE

# EXAMPLE OF HOSPITAL ACCOUNT

| XXXXXXXXX AVENUE<br>XXXXXX<br>1111<br>All prices include VAT @ 15.00 % | XXXXXXX HOSPITALS (PTY) LTD T/A | | |
|---|---|---|---|
| | Practice Nr<br>Reg. No<br>Tel Nr<br>Fax Nr<br>Vat Reg | : 00000000<br>: 1111/11111/11<br>: 000 000 0000<br>: 000 000 0000<br>: 000 000 0000 | P.O BOX 1234<br>1111<br>000 0000 |

| TAX INVOICE | **Page: 1** |
|---|---|
| | **Date: 09.07.2018** |
| Mrs Jones<br>111 Aaaaaaaaa<br>Aaaaaaaa<br>AAAAAAAAAA<br>1111 | Customer Number: 1000000000<br>Case Number: 1000000000<br>From Date: 10.05.2018 13:41:23<br>To Date: 12.05.2018 11:00:00 |

| **Patient Name** | : Mrs Jones | **Forename** | : Jane |
|---|---|---|---|
| **Medical Aid** | : Premium | **D.O.B** | : 01.01.1999 |
| **Member No** | : 123456789 | **Employer** | : Abcdef |
| **Dependant Code:** | : 00 | **ID Number** | : 1111111111111 |
| **Attn.doctor** | : Smith | **Practice No:** | : 1234567 |

| MAIN HOSP DIAGN : O30.0 | | | | |
|---|---|---|---|---|
| POSTING DETAILS | | | | |
| **POSTING TYPE** | | | **MED.AID** | **PRIVATE** |
| Ward Fees | | | 15,000.11 | 0.00 |
| Ward Drugs | | | 500.22 | 0.00 |
| Other Non-Drugs Charges - WRD | | | 0.00 | 0.00 |
| Theatre Fees | | | 7,333.33 | 0.00 |
| Prosthesis / Fixators | | | 0.00 | 0.00 |
| Theatre Drugs | | | 1234.00 | 0.00 |
| Other Non-Drugs Charges - THR | | | 800.00 | 0.00 |
| Dispensary Drugs | | | 250.00 | 0.00 |
| Dispensary Drugs - TTO | | | 0.00 | 0.00 |
| Dispensing Fee | | | 0.00 | 0.00 |
| | | | | |
| TOTAL OWING | 25,117.66 MED/PVT SPLIT ---> | | 25,117.66 | 0.00 |

| BANKING DETAILS: | | | |
|---|---|---|---|
| Account Name | : Xxxxxxxx Hospital | | |
| Bank/Branch | : Xxxxxxx | Branch Code | : 000000 |
| Account No | : 12312312312 | Fax No. | : 111 111 1111 |
| Reference No | : 111222333444 | | |

PLEASE QUOTE YOUR CASE NUMBER AS INDICATED ABOVE AND FAX YOUR DEPOSIT SLIP.

EXAMPLE

# EXAMPLE OF HOSPITAL ACCOUNT

| XXXXXXXXX AVENUE<br>XXXXXX<br>1111<br>All prices include VAT @ 15.00 % | XXXXXXX HOSPITALS (PTY) LTD T/A | | |
|---|---|---|---|
| | Practice Nr<br>Reg. No<br>Tel Nr<br>Fax Nr<br>Vat Reg | : 00000000<br>: 1111/11111/11<br>: 000 000 0000<br>: 000 000 0000<br>: 000 000 0000 | P.O BOX 1234<br>1111<br>000 0000 |

| TAX INVOICE | **Page: 2** |
|---|---|
| | **Date: 09.07.2018** |
| Mrs Jones<br>111 Aaaaaaaaa<br>Aaaaaaa<br>AAAAAAAAAA<br>1111 | Customer Number: 1000000000<br>Case Number: 1000000000<br>From Date: 10.05.2018 13:41:23<br>To Date: 12.05.2018 11:00:00 |

| **Patient Name** | : Mrs Jones | **Forename** | : Jane |
|---|---|---|---|
| **Medical Aid** | : Premium | **D.O.B** | : 01.01.1999 |
| **Member No** | : 123456789 | **Employer** | : Abcdef |
| **Dependant Code:** | : 00 | **ID Number** | : 1111111111111 |
| **Attn.doctor** | : Smith | **Practice No:** | : 1234567 |

| **CONFIRMATIONS** | | | |
|---|---|---|---|
| Date | : 09:16:23 | 15,000.11 | 0.00 |
| User | : 00012345 | 500.22 | 0.00 |
| Auth Number | : 123456789 | 0.00 | 0.00 |
| Authorised Limit : | : 0.00 | 7,333.33 | 0.00 |
| Prosthesis Limit : | : 0.00 | 0.00 | 0.00 |
| Remarks | | 1234.00 | 0.00 |
| | | | |
| **ICD CODES** | | | |
| O30.0 | | 250.00 | 0.00 |
| P03.4 | | 0.00 | 0.00 |
| | | | |
| **CPT CODES** | | | |
| 11111 | | | |
| 22222 | | | |
| | | | |
| **LEVEL OF CARE** | | | **DAYS** |
| 58001-General Surgical | | | 3.0 |
| **Length of Stay** | | | **3.0** |

EXAMPLE

# EXAMPLE OF CO-PAYMENT RECEIPT


UCT MEDICAL CENTRE LTD

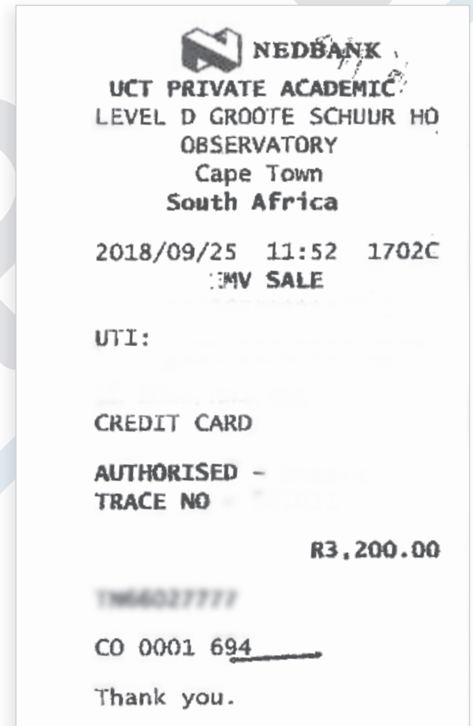
PRACTICE NO.:
REG. NO.:
VAT NO.:

BLOCK D, GROOTE SCHUUR HOSPITAL
ANZIO ROAD, MOWBRAY, 0000

PO BOX 0000
MOWBRAY, 7705

Phone: 021 000 0000
Fax: 021 000 0000


RECEIPT CONFIRMATION



NEDBANK
UCT PRIVATE ACADEMIC
LEVEL D GROOTE SCHUUR HO
OBSERVATORY
Cape Town
South Africa

2018/09/25 11:52 1702C
EMV SALE

UTI:

CREDIT CARD

AUTHORISED -
TRACE NO

R3,200.00

CO 0001 694

Thank you.

PAYER NAME:
Mr Joe

CUSTOMER NO.:
10101010101010

MEDICAL AID:
Medical Aid Co

MEMBERSHIP NO.:
10101010101010

CUSTOMER NAME:
Mr Joe

| Date | Case Number | Receipt Number |
| --- | --- | --- |
| 25.09.2018 | 10101010101010 | 1010101010101010 |

| Description | Amount |
| --- | --- |
| PATIENT RECEIPTING | R3,200.00 |

THANK YOU FOR YOUR BUSINESS

EXAMPLE

# Total Risk Administrators

## GAP COVER CLAIM FORM

Underwritten by:

An authorised Financial Services Provider I FSP no. 40815
T: 011 372 1540 | F: 011 372 1579 | www.totalrisksa.co.za

Auto & General Insurance Company Limited,
a licensed non-life Insurer & Financial Services Provider -
Reg No 1973/016880/06

### IMPORTANT INFORMATION!

**Please complete the form and return to Total Risk Administrators for attention TRA Claims Department via email to claims@totalrisksa.co.za OR by fax to 011 372 1579 OR by post to P.O. Box 8012, Greenstone, 1616**

### SECTION 1: PERSONAL DETAILS

| | | | |
|---|---|---|---|
| Medical Scheme | | Med Aid No | |
| Option | | Gap Policy No | |
| Title | ☐ Mr ☐ Mrs ☐ Ms ☐ Other | Initials | |
| First Names **(in full)** | | | |
| Surname | | | |
| Date of Birth | Y Y M M D D | ID Number | |
| Contact Numbers | | | |
| Email Address | | | |

| POSTAL ADDRESS | COMMENTS |
|---|---|
| | |
| | |
| Code | |

### SECTION 2: CLAIM DETAILS

| Beneficiary Name | Treatment Date | Provider Name | Practice Number | Amount Claimed |
|---|---|---|---|---|
| | Y Y M M D D | | | |
| | Y Y M M D D | | | |
| | Y Y M M D D | | | |
| | Y Y M M D D | | | |
| | | | TOTAL | |

**It is very important that the medical aid statement reflecting the claims submitted, the hospital account and the doctor's statements are provided with this claim! If these documents are not attached it will be considered an invalid claim.**

### SECTION 3: REQUIRED DOCUMENTATION

The following documentation is required BEFORE a claim can be processed:

☐ First 2 pages of Hospital Account ☐ Medical Aid Statement ☐ Doctor / Service Provider Statement

Please use the tick boxes above to ensure you have included the required documentation.

When submitting a CO-PAYMENT claim, please include the following documentation:

☐ Medical Aid Pre-authorisation letter showing requirement of co-payment

☐ Proof of payment of co-payment to provider

**All claim refunds will be paid into the bank account as per our system. For banking detail changes, please contact our Membership Department on membership@totalrisksa.co.za / 011 372 1540**

I, ______________________________________________

the undersigned, declare that the afore-going details are, to the best of my knowledge true, correct and complete.

MEMBER SIGNATURE

Date Y Y M M D D

**As per the terms and conditions of this policy all the required information must be submitted to TRA within 6 months from date of treatment after which the claim will be considered "stale". Refunds are generally made directly into the policyholder's bank account.**