REIMBURSEMENT PROCEDURES

This letter is to inform your staff of our reimbursement procedures, there has been many confusions as to what to include when submitting a claim and the time it would take to receive the payments back. Please advise your staff of these important steps before submitting a claim to Takaful.

REMINDERS

1) Use our many hospitals on our panel list to avoid paying out of your pocket
2) If you are going out of the country to get treatment you MUST get referral from at least 2 local doctors and also advise Takaful in advance to make the necessary arrangements.
3) If you are going to a Hospital that is NOT on our panel be prepared to pay for the services upfront, also expect to receive reimbursement within 14 working days; unless documents are incomplete.

REIMBURSEMENT FORM CHECK

Reimbursement form **MUST** be filled out and include the following

- MEMBER ID | PHONE NUMBER | SIGNATURE
- HOSPITAL STAMP & DOCTORS SIGNATURE
- DIAGOSTIC SECTION FILLED OUT
- TYPE OF SICKNESS
- HOSPITAL NAME
- ACCOUNT INFORMATION

SUBMITTING A CLAIM

When you are submitting a reimbursement you **MUST** include the following:

- **CLAIMS MUST BE SUBMITTED WITHIN 30DAYS**
- COMPLETED REIMBURSEMENT FORM
- ALL MEDICAL RECEIPTS
- DROP OFF ALL DOCUMENTS ATTACHED TO YOUR HR
- WAIT APPROX 2WEEKS TO RECEIVE BACK YOUR PAYMENT

Please share this with your staff and we highly suggest they use the Hospitals list in our panel. Any questions regarding reimbursements, hospitals list, claims inquires. PLEASE use this email address Medical@takaafulafrica.com

- **Dear Doctor**, we thank you for filling in medical sections **B** of this claim form and for signing, dating and stamping it.
- **Dear Member**, we thank you for completing sections **A** of this claim form and for signing and dating it. **All fields on the page are compulsory. Claim Must Be Submitted Within 30 Days.**

TAKAFUL INSURANCE OF AFRICA
A bond beyond insurance

MEDICARE TAKAFUL REIMBURSEMENT CLAIM FORM

PART A: To be completed by the Patient / Principal Member

Patient's Name		Membership No	
Employee's Name		Relation	
Employer's Name		Mobile No	

Is the claim covered by other Insurance? If Yes, please enclose details	**Yes** ☐	**No** ☐
Did you get admitted for this kind of illness in any Hospital within last three months' time?	**Yes** ☐	**No** ☐
If **YES**, mention the name of the Hospital		

Payment Method	☐ **Bank Payment** ☐ **Remittance**			
If Selected Bank Payment	**Account Name:**			
	Account No			
Bank Name:		**Bank Address**		
If Selected Remittance	**Name**			
	Mobile No		**Location**	

DECLARATION: I confirm that the information I have given on this form is accurate, to the best of my knowledge. I hereby authorize TIA to discuss, access and obtain a copy of my health records (or any of my dependents' records) that may be requested by them or their appointed representative. I also agree that a copy of this declaration stands valid as original. I understand that in the event that terms and conditions of my plan have not been met Hospital reserves the right to recover any costs directly from the plan holder or myself.

Signature of Patient/Principal Member	
Signature	**Date**

PART B: To be completed by the Attending Physician or Treating Doctor

☐ **Sickness** (State)	☐ **Acute**	☐ **Chronic**	☐ **Congenital/Hereditary**	☐ **Work Related**	☐ **Pregnancy**	
☐ **Accident** (State Nature of Injuries:						
☐ **New Visit** ☐ **Follow-up**	☐ **Outpatient(OP)**	☐ **Emergency OP**	☐ **Day Care**	☐ **Dental**	☐ **Optical**	
In case of IN-PATIENT admission	**Admission Date**		**Discharge Date**			
Diagnosis and Findings						

PHYSICIAN/DOCTOR'S DECLARATION

I hereby certify that all medical information mentioned is to the best of my knowledge true and the medical services shown on this form are medically indicated & necessary for the management of the patient medical condition.

Treating Doctor's Name:
Specialty:
Contact No.: **Doctor's Signature & Stamp:**

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