MAKOTI
MEDICAL SCHEME

MEMBER REFUND FORM

Please complete this form when you had to pay for medical services and require a refund.
Attach the following documentation to the member refund form:

1. **Detailed account** from your Service Provider and a **Receipt**
2. Pharmacy claim: a **script Printout**, and **a Proof of Payment**

Please Fax your claim to: **086 660 7023** or email: **admin@enablemed.com**

REFUND DETAILS

DATE COMPLETED: D D M M Y Y Y Y

MEMBER SURNAME:

IDENTITY NUMBER:

MEDICAL AID NO:

TELEPHONE NUMBERS: (WORK)

(CELL)

PATIENT NAME:

DATE OF BIRTH: D D M M Y Y Y Y

PRACTICE NO:

NAME OF SERVICE PROVIDER:

DATE OF SERVICE: D D M M Y Y Y Y

REASON FOR REFUND:

AMOUNT CHARGED: •

AMOUNT PAID: •

MEMBER BANKING DETAILS

ACCOUNT NAME:

BRANCH CODE:

BANK:

BRANCH:

ACCOUNT NO:

MEMBER SIGNATURE

DATE: D D M M Y Y Y Y

Enablemed

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