

# EDGARS Club Zimbabwe

## Hospital Cash Plan Claim Form

NB: ALL QUESTIONS MUST BE ANSWERED

CONTACT DETAILS.....

1. Full Name Of Insured.....
2. Policy Number / Cell Number.....
3. Patient / Dependant Hospitalised.....
4. Address.....
5. Indicate reason for hospitalisation( Tick )  
(a) illness  (b) accident
6. (a) Date Admitted.....  
(b) Time of Admission.....
7. (a) Name of admitting doctor.....  
(b) His/Her AHFOZ number.....
8. (a) Date discharged.....  
(b) Time of Discharge.....
9. (a) Name of discharging doctor.....  
(b) His/Her AHFOZ number.....
10. Name of Hospital.....
11. Medical aid provider, if any.....

Date.....Signature.....

### Documents required to process Claim

- 1) Doctor's confirmation of stay in hospital
- 2) ID which includes passport, driver's license, National ID, Birth Certificate for children
- 3) Confirmation of medical aid, if applicable. (Copy of medical aid card will suffice)
- 4) Hospital Statement or Final Bill

**Insurance Fraud is a Crime**

# Hospital Discharge/Review Script

(To be completed by the Doctor/ Sister in Charge)

Patient's Name.....Hospital No.....

Address.....  
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Date of Admission.....Time.....

Date Of Transfer/Discharge.....Time.....

If Transfer, Transferred to.....

Final Diagnosis.....

Investigations/Tests.....

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Treatments.....

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Date Of Review.....

**Hospital Stamp**

Name & Signature Of Doctor/Sister In Charge

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## Payment Details

Bank Name & Branch.....

Account Holder's Name.....

Account Number (ZWL.....

Account Number (USD).....

**Note: All sections must be completed. This form must be stamped by the hospital for it to be considered valid**