

ClaimSmart

Client Intake & Case Information Form

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Please complete the sections that apply to your matter. You do not need to complete every section. If you are unsure, leave it blank and we will guide you.

1. About you

Full name & surname	ID / Passport number
Mobile number	Email address
Medical aid scheme	Plan / option
Membership number	Main member name

☐ I am the main member ☐ I am a dependant

2. What would you like help with?

- ☐ Rejected / unpaid claim ☐ Claim query / resubmission ☐ Chronic medication ☐ PMB application
☐ Authorisation ☐ Benefits / special benefit ☐ GAP Cover claim ☐ Hospital / specialist shortfall
☐ Extended medicine supply ☐ Medical device / supplies ☐ Other

Briefly tell us what happened and what you would like ClaimSmart to help with:

3. If this is about a claim

Complete only if relevant.

Patient name	Date of treatment / service
Healthcare provider	Claim / reference number
Amount charged	Amount paid by medical aid

Amount paid by you	Reason rejected / unpaid (if known)
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4. If this is about medication, PMB or an authorisation

Complete only if relevant.

☐ New authorisation ☐ Re-authorisation ☐ Follow-up ☐ Rejected authorisation ☐ PMB query ☐ Chronic medication issue

Patient name	Medication / treatment / procedure
Condition / reason (if relevant)	Doctor / specialist
Authorisation number (if any)	Authorisation expiry date

5. If this is about GAP Cover or a shortfall

GAP Cover provider	Policy / membership number
Patient name	Date of treatment
Hospital / provider	Medical aid claim number
Shortfall / co-payment	GAP claim number (if submitted)

6. Documents you have

☐ Medical aid statement ☐ Rejection / claim response ☐ Provider invoice ☐ Prescription / referral
☐ Authorisation letter ☐ Hospital / specialist account ☐ GAP documents ☐ Previous correspondence

Other / documents still outstanding:

7. Previous action taken

☐ I have already contacted the medical aid / provider ☐ I have not contacted them yet

Date contacted	Reference number
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Outcome / response received:

8. Confirmation

I confirm that the information I have provided is accurate to the best of my knowledge. I authorise ClaimSmart to assess this matter and provide the administrative support I request. I understand that ClaimSmart cannot guarantee payment, approval or a particular outcome, as decisions remain with the relevant medical scheme, GAP Cover provider or other third party.

I confirm that I have received, read or been given access to the ClaimSmart Service Agreement and POPIA & Medical Information Consent.

Client full name	Signature	Date