BMW Employees Medical Aid Society

Administered by Discovery Health

Contact details
Tel: 0860 002 107 • PO Box 652509, Benmore 2010 • www.bemas.co.za

Request to reverse the payment of a claim that BEMAS received and paid

Who we are
The BMW Employees Medical Aid Society (referred to as 'BEMAS'), registration number 1526, is a not-for-profit organisation, registered with the Council for Medical Schemes.
Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for BEMAS.

How to complete this form
1. Please use one letter per block, complete in black ink and print clearly.
2. Please ensure the main member signs and dates the form.
3. Once complete, please fax your form to 0860 235 878 or email it to **claimsadjustments@discovery.co.za**

When you sign this application, you confirm that you have read and understood the requirements and that the information is true and complete.

1. About the main member

Title | Initials | Surname

Identity Number | Date of birth (D D - M M - Y Y Y Y)

Passport number

Membership number

Telephone (H) - | (W) -

Cellphone - | Fax -

E-mail address

2. About the claim that you want the Society to reverse

Details of the claim that the Society paid and that you want reversed:

Service date (D D M M Y Y Y Y) | Practice number

Practice name or name of healthcare provider

Claim reference number (if available)

Healthcare service

Amount claimed | Amount that the Society paid

Please give a brief explanation of why you want the payment for this healthcare service reversed

BEMRRP001

3. Important information about your request to reverse payment of a claim

1. Please be aware that when we reverse the payment we made for this healthcare service, the healthcare provider may still hold you responsible for the payment.
2. You agree that when the Society reverses the payment we made to you or to the provider, we will not process or pay this claim again.
3. You agree that we let the healthcare provider know of your request to have this payment reversed. We may also give this confirmation to the healthcare Provider in writing.

Main member's name | Date D D - M M - Y Y Y Y

Main member’s signature

Please do not sign an incomplete application form