

How to claim from medical aid?

(Please be advised that we have a Medical aid Claims department that are more than willing to help with all enquiries and even the claims and submissions thereof.)

Please remember that when you submit your claims, your submission must include a complete quote/invoice for the service rendered.

Before you can claim a benefit for a medical appliance from your medical aid, you (or us as your proposed service provider) typically need to make an **enquiry and obtain pre-authorisation** from the scheme.

This process helps confirm:

- Whether the specific appliance is covered by your plan and available benefits.
- If a waiting period applies (especially for new members).
- If you need to use a designated service provider (DSP) or if a cost difference will be your responsibility when using another provider.

Steps for Benefit Enquiry and Claiming

1. **Verify Your Benefits:** Review your medical aid's benefit guide or contact the scheme directly to understand your specific "External Medical Items" (EMI) or "Medical and Surgical Appliances" limits and rules. Schemes like GEMS and Discovery have online portals or phone services to check benefits.
2. **Obtain Required Documentation:** Your healthcare provider will typically need to provide:
 1. A letter of motivation.
 2. A quotation from a registered provider (with a practice number).
 3. The relevant diagnosis (ICD-10) code and a description of the device (including its Nappi code).
3. **Request Pre-Authorisation:** Submit the documents to your medical scheme via email, or their online portal *before* obtaining the appliance. They will then assess the request and inform you of the outcome, including any potential shortfalls or co-payments.
4. **Purchase from a DSP (if required):** To avoid out-of-pocket payments, use a network provider as advised by your scheme's authorisation letter.
5. **Submit the Claim:** If you had to pay upfront (e.g., if the provider is not a DSP), you must submit a claim form along with the original invoice and proof of payment to the scheme for reimbursement. Ensure all details are correct and complete to avoid rejection.

Information Needed for Your Claim:

- Your Membership Number
- Principal Member's Name & Initials
- Patient's Name (if different)
- Date of Treatment
- Service Provider's Name & Practice Number
- Amount Charged
- ICD-10 Code (for diagnosis)
- NAPPI Code (if applicable)

Submitting Your Claim:

- **Provider Submits:** The provider sends the invoice directly to your medical aid.
- **You Submit:** Upload via your scheme's website/app (PDF, JPG) or email/post.

Key Deadlines & Tips:

- **4-Month Rule:** Submit claims within four months of the service date, or they might expire.
- **Stay Updated:** Keep your contact details current with your medical aid

To follow up on a medical aid claim, you should first check your medical scheme's online portal or app. If an online check is not possible or the status is unclear, contact your medical scheme directly using their dedicated member service or claims department contact details, ensuring you have all relevant information ready.

Steps to Follow Up on Your Claim

1. **Gather Necessary Information:** Before you begin, have the following details on hand:
 - Your medical aid membership number.
 - The patient's name and date of birth.
 - The healthcare provider's name and practice number.
 - The date of the service rendered.
 - The amount charged and relevant codes (tariff and ICD-10 diagnosis codes).
 - The claim number or reference number (if you have one).
 - Proof of payment (if you paid the provider directly).

2. **Check Online or via App:** Most medical schemes offer a member zone on their website or a dedicated mobile app where you can track the status of your claims. This is often the quickest way to get an update.
3. **Contact Your Medical Scheme Directly:** If online tools aren't available or don't provide sufficient detail, contact your scheme's client service or claims department by phone or email.
 - **Phone calls:** Use the general query or claims number provided by your scheme. Make sure to note the reference number provided during the call for any future communication.
 - **Email:** Send an email to the specific claims or member service email address. Include your membership number in the subject line for efficient processing.
4. **Review Your Claims Statement:** Medical schemes typically send out statements after processing claims, either monthly or after each payment run. Review this statement for reasons why a claim may have been rejected, short-paid, or not processed (e.g., benefits depleted, incorrect information, late submission).
5. **Address Rejections or Short Payments:** If a claim is rejected, determine the reason from your statement or by contacting the scheme. You may need to provide additional clinical information, a pre-authorisation number, or correct billing errors and resubmit the claim within the specified timeframe (usually within 60 days for resubmissions, but original claims must be within four months of the service date).