HERITAGE HEALTH

We care about your health

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A. Accident/ Injury Report

Principal Member Details Below

Membership Number

Surname

First Names

Personal Postal Address

Tel Code and Number

Fax Code and Number

Cell Phone Number

Email Address

Date of Birth D D M M Y Y Y Y

Gender Male Female

ID/Passport Number

B. Particulars of member who was in accident or who was injured

Full Names of Patient

Tel Code and Number

Fax Code and Number

Cell Phone Number

Email Address

Date of Birth D D M M Y Y Y Y

I AUTHROISE THE MEDICAL AID FUND TO OBTAIN MORE CLINICAL INFORMATION ON MY/OUR BEHALF

....

SIGNATURE PRINCIPAL MEMBER/PATIENT DATE

C. Accident Injury Detail

Explain briefly why the treatment was necessary, clinical and diagnostic information

D. Where, when and how did the accident/injury take place

Are you covered by a personal/company accident form? Yes ☐ No ☐

If yes, please confirm where ☐

Your policy number at the insurer ☐

E. Motor Vehicle Accident Information

Please Note: You remain responsible to refund any reimbursements received to Heritage Health.

Have you informed the MVA Fund of the accident within 60 days of the date of the incident? ☐

Have you logged a 3rd party claim and provide proof? ☐

Consent to release clinical information for all hospitalisation that may relate to an accident or injury

I ______________________________, hereby authorise the hospital to provide all the necessary clinical information relating to my hospitalisation to the Fund and its representatives.

_______________________________ _______________________

SIGNATURE OF MEMBER DATE
(or authorised representative)

Undertaking to refund any payments received in lieu of the accident to the Fund within 7 days from date of receipt of the funds.

I ______________________________, hereby undertake to refund any payments in lieu of the accident to the Fund within 7 days of receipt of the funds from the MVA Fund.

_______________________________ _______________________

SIGNATURE OF MEMBER DATE
(or authorised representative)

E. Accident / Injury Processing *(office use)*

Date received: ....

Date processed: ....

Approved: ....

Declined and reason: ....

Inform patient: ....

Employee name: .... Signature: .... Date: ....