PREMIER HEALTH INSURANCE
Your bridge to premier healthcare

Ref:.....

Date:.....

*Uncompleted forms will not be attended to (Required fields are marked with *****)*

CORPORATE REFUND FORM

*NAME OF MEMBER ACCESSING HEALTHCARE:		
*COMPANY/INSTITUTION:		
*MEMBERSHIP #	*TELEPHONE:	E-MAIL:
*NAME OF PRINCIPAL MEMBER/STAFF:		

***BANK ACCOUNT DETAILS:** (ACCOUNT NAME) *ACCOUNT NUMBER

*BANK *BRANCH *BRANCH SORT CODE

***MOBILE MONEY DETAILS: (**ACCOUNT NAME) *MOMO ACCOUNT NUMBER

RELEVANT DOCUMENTS ATTACHED (PLEASE TICK)

PRESCRIPTION ☐	REFERRAL NOTE ☐	RECEIPTS ☐	LAB. REQUEST ☐

NO.	NAME OF HEALTH FACILITY	AMOUNT (GH₵)
1.		
2.		
3.		
4.		
TOTAL		

*REFUND ISSUES

A. PLEASE SUMMARISE YOUR REASON S FOR PAYING CASH AT THE FACILITY:
B. PLEASE INDICATE SUGGESTIONS TO FORESTALL THE ISSUES IN (A) ABOVE:

* FOR HR/OFFICER-IN CHARGE (ALL REFUNDS SHOULD BE ENDORSED BY HR)

NAME:	TELEPHONE: E-MAIL:	STAMP, SIGNATURE & DATE:

CONDITIONS GOVERNINGREFUNDS

1. Refunds are permitted ONLY FOR EMERGENCIES and for cases that the Scheme has received Pre-Authorization.
2. Refund Claims are vetted before they are paid. Please ensure that all relevant documents to support the claims are attached.
3. Refunds are to be submitted for processing within three (3) months of receiving medical attention after which they go stale.
4. Payment for Stale Refund Claims are not honoured.
5. *The Scheme reserves the right to consider payment of refund claims up to a maximum of 70% for all bills accrued for members who accessed a facility they are not entitled or unaccredited facilities for which no PRE-AUTHORIZATION was received.*