Complaints and Dispute Resolution Form

POLMED
OUR INVESTMENT OUR HEALTH OUR FUTURE

POLMED Client Service Call Centre:0860 765 633

Postal address: Private Bag X16, Hatfield, Pretoria, 0001

Email: Polmedappeals@medscheme.co.za

COMPLAINT LODGED IN TERMS OF RULE 28 OF THE SCHEME RULES/SETTLEMENT OF DISPUTES AND COMPLAINTS

NAME AND SURNAME OF MEMBER:

NAME AND SURNAME OF COMPLAINANT: *(The Third Party Consent form as required in terms of the Protection of Personal Information (POPI) Act must be completed and signed by the member/beneficiary – this is applicable if complaint is submitted on behalf of member/beneficiary).*

MEMBER/BENEFICIARY DETAILS:

Membership Number:	
Identity Number:	
Benefit Option:	
Dependant Code:	

IMPORTANT: *Kindly note that confidential and/or medical information will be communicated to the address/email provided. Please ensure that you provide the correct contact details (post/email/cellphone) for this purpose. POLMED does not accept responsibility for sensitive information being sent to the wrong address or receipt thereof by unauthorised persons.*

CONTACT DETAILS:

Postal Address:	
Postal Code	
Contact Number (Cellphone):	
Contact Number (Telephone):	
Email Address:	

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DETAILS/NATURE OF COMPLAINT:

Please provide a summary of the facts of the matter and attach any supporting documentation i.e medical reports, claims, statements, applications, Scheme letters, etc.

DETAILS OF DISPUTE RESOLUTION PROCESSES FOLLOWED:

Indicate what processes were followed before submitting this appeal.

WHAT RECOURSE DO YOU REQUIRE?

Complainant _____

Date D D M M Y Y Y Y

RULE 28.6

The complainant shall have the right to appeal to the Council for Medical Schemes (email: complaints@medicalschemes.com) against the decision of the Complaints Dispute Resolution Committee.

Such appeal shall be in the form of an affidavit directed to Council and shall reach the Registrar not later than 3 months after the date on which the decision by the Disputes Committee was made.