HYGEIA HMO

ENROLLEE REFUND FORM

(For Refund for Medical Claims submitted by enrollee)

Enrollee's Last Name	First	Middle	Enrollee Birth date (Day/mo/yr)	Enrollee's relationship to *Staff* *(Check One)*	M	F
				Self	☐	☐
				Spouse	☐	☐
				Child(ren)	☐	☐
				Other	☐	☐

Name of Company	Enrollee Identification number

Enrollee's Street Address	City	State

Enrollee Registration Date (Day/mo/yr) Date of encounter (Day/mo/yr)

Name of Provider

Description of illness or injury

Reason for Refund (Select one)

Visited Out of network provider in an emergency
Selected provider requested payment for covered services
Others_____

Please include the following supporting documents in order to process claim

A) Medical Report
B) Original Receipt of Payment
C) Breakdown if cost and details of each procedure and medication with list of each
D) Others, please list _____

Tel No:_____ **Email Address:** _____

Alternate Email Address: _____

Total Amount Claimed:_____ **A/C Number:** _____

Account Name:_____ **Bank Name:** _____

Enrollee/Legal Guardian or Representative Agreement:

I certify that all of the above information is accurate to the best of my knowledge; I agree to reimburse Hygeia HMO if a claim refund madeto me is later found to be more than I was entitled to receive or that I am not entitled to the refund. (If this claim form is signed by enrollee's Parent or legal guardian, these statements are agreed to by the signer on behalf of the enrollee).

Data Subject Privacy and Consent Statement

I hereby confirm that I have the legal capacity to give consent and hereby voluntarily grant my consent to Hygeia HMO Limited (Hygeia) and its duly appointed representatives, authority to access, retrieve, process, store, transfer as well as use for any legitimate and lawful purpose, my personal and/or medical information including all relevant data envisaged by the extant law including but not limited the Nigerian Data Protection Regulation (and any amendment thereto) as well as the Nigerian Data Protection Act (and any amendment thereto) solely for the purpose of carrying out their duties and responsibilities as my health insurance Company and providing health maintenance services. I am aware that my information may be shared with third-party service providers of Hygeia HMO for these purposes, and Hygeia HMO shall take measures to protect the said information. I confirm that I am aware of my rights, labilities and method to withdraw my consent herein at any time by notifying Hygeia HMO in writing and accordingly request that this consent remain in full force and subsist until such a time as when I withdraw same. In addition, where applicable, I confirm that I am the duly authorized representative of my minor children, wards, aged parents and any legal Dependents and accordingly, I hereby grant same consent to Hygeia HMO on behalf of all my dependant(s) who are minors and accordingly request that this consent remain in full force and subsist until such a time as when I withdraw same or such a time when my minor dependent each personally withdraws same after attaining the statutory age of majority.

(Name/Signature) _____ *Date* _____

For Official Use Only (to be completed by Hygeia HMO Official)

Did the enrollee/client contact Hygeia HMO within 24 hours of seeking care outside the network? *Yes* ☐ *No* ☐

*Confirmed by Client Mgr/Care Coordinator Name:*_____ *Signature:*_____

Refund Approved? *Yes* ☐ *No* ☐ *Reason:*_____

*Refund Amount Approved*_____ *Reason for variation between amount claimed and amount approved:*

_____

If provider is in network and provided services are covered, should refund be deducted from Provider capitation? Yesf ☐ *No* ☐ *If No, Please give reason*

_____

Supporting Document attached? ☐ *Yes* ☐ *No*

Investigated by (Client Mgr/Care Coordinator)

*Name*_____ *Signature*_____ *Designation*_____ *Date:*_____

Approved by (MD/COO/HPS)

*Name*_____ *Signature*_____ *Designation*_____ *Date:*_____