



NET6181  
05/13  
OG

Dear Patient

## Valuable Information on your Hospital Account and Case Management

Your doctor(s) make the relevant diagnosis(s) and decides on your treatment, and the hospital as the service provider, abides by the doctor's decision.

**As a member of a Medical Aid, it is important to remember that you have a responsibility to ensure the following:**

- You are aware of your benefits, co-payments, limits, exclusions and waiting periods
- You are aware of items and procedures not covered
- You are aware of the available benefits in your savings account
- You are aware of preferred providers/designated service providers
- You are a valid member
- All premiums are paid up to date

Admission to any Netcare Hospital's Facility is subject to the Netcare Hospital Terms & Conditions. The terms and conditions in respect of among other things, payment of the Netcare Hospital's fees are set out therein.

You are personally responsible for payment of the Netcare Hospital's fee whether or not the fee is submitted to any third party including your medical aid for payment.

**Please take note that an authorisation number is not a guarantee of payment and you are responsible for obtaining the authorisation.**

- Your medical aid will never decline the treatment, but they do in certain instances, refuse payment.
- Your medical aid may request, motivation from your doctor(s) for certain procedures and/or the treatment prescribed.
- Your medical aid may at times pend the authorisation for outstanding information or documentation.
- Remember that you are at all times liable for payment of the Netcare Hospitals fee.
- Please keep in mind that although your medical aid can request motivation from your doctor(s), the Netcare Hospital cannot write a motivation on the doctor's behalf.
- **Your medical aid can at times retrospectively decide not to cover the account, part of the account, or certain items on the account. It is imperative to know that the hospital is not aware of which items a doctor will prescribe prior to the treatment nor the decision of your scheme on these items whether they will cover it or not.**
- Should this be the case, you are held liable for any outstanding amounts not paid by your medical aid. Should you require a list of excluded items as per your medical aid rules, you may obtain such list from your scheme or request it from the hospital.
- Please be aware that we are obliged to and will dispense the generic equivalent of the prescribed medication unless your express Instructions are to the contrary.

**To facilitate payment from your medical aid, Netcare Hospitals will:**

- Update the medical aid with ICD 10 coding. This is a diagnostic coding. ICD 10 coding is a legal requirement and it is expected to be on all accounts sent to your Medical aid. Without accurate coding your account cannot be processed by your medical aid.
- We will also inform the medical aid of your:
  - a. diagnosis and illness/injury
  - b. all procedures
  - c. all clinical information related to your stay
  - d. all medication
  - e. all treatmentincluding any changes thereto
- Should you not want details of your diagnosis, procedure, medication and treatments to be shared with your medical aid, the medical aid will be informed in coding format that you decline disclosure of that information. In that case your Medical aid may refuse payment of the account and the account will be recorded as a private account in Netcare Hospitals' records. Be aware that the Netcare Hospital Contract contains a consent to disclose the nature of the patient's diagnosis and/or any health services rendered to the patient and all and any records or copies of records in relation thereto to your medical aid or a third party for the purpose of authorisation of the health services and/or payment of the Netcare Hospital's fee.

**Refunds to members:** Where a medical aid member made a payment towards the account (based on co payments, scheme exclusions, etc) and the medical aid indicates that they will pay the full account (including the private portion); the payment must first be made by the scheme before a refund will be issued. The refund will be issued to the person who made the payment (payee) and this process may take up to 14 days after settlement by the scheme. As a security measurement, no cash refunds are allowed.

**I have read, understood and take note of the above content.**

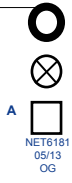
\_\_\_\_\_  
Patient Date

\_\_\_\_\_  
Parent/Guardian (if minor child) Date

\_\_\_\_\_  
Guarantor Date

**Patient Sticker**

\_\_\_\_\_  
Hospital Staff Member



# ADMISSION CONTRACT

**NETCARE HOSPITAL CONTRACT**Governing Terms  
and Conditions

Admission to the Netcare Hospitals Facility, and the use of facilities including but not limited to theatre and wards, and the rendering of all health services to the patient by Netcare Hospitals is subject to, and on the terms and conditions set out in this Netcare Hospital Contract.

**PATIENT DETAILS\***

Title			Surname		
First Name(s)					Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
ID/Passport No.			Date of Birth		
Nationality			Language		
<b>E-mail Address</b>				Vehicle Reg. No.	
Home Tel No.			Cellphone No.		
<b>Physical Address*</b>	Unit No.			Complex Name	
Street No.			Street Name		
Suburb/District			City/Town		
<b>Postal Address*</b>	Post Box/Private Bag				
Suburb/District			Country		
<b>Employment Information</b>					
Name of Company			Occupation		
Employee No.			Period of Employment		
<b>Physical Work Address</b>	Unit No.			Complex/Building Name	
Street No.			Street Name		
Suburb/District			City/Town		
<b>Work E-mail Address</b>				Work Tel No.	
<b>Next of Kin*</b>					
Surname					
First Name(s)			Relationship to Patient		
<b>Physical Address</b>	Unit No.			Complex Name	
Street No.			Street Name		
Suburb/District			City/Town		
Home Tel No.			Work Tel No.		
<b>Other Contact Person* (Not residing with you)</b>					
Surname					
First Name(s)			Relationship to Patient		
<b>Physical Address</b>	Unit No.			Complex Name	
Street No.			Street Name		
Suburb/District			City/Town		
Home Tel No.			Work Tel No.		
<b>IF FOREIGN PATIENT</b>					
<b>Address Whilst in SA</b>	Unit No.			Complex Name	
Street No.			Street Name		Tel No.
Suburb/District			City/Town		
* In the case of non-South African resident patients, record physical and postal address in country of origin, and record details of next of kin and contact persons both in the patient's country of origin and in South Africa if possible.					

**Admission Details**

Admitting Doctor			Referring Doctor		
Family Doctor/GP					
Patient's Diagnosis					
Date of Procedure			Procedure Code		
Date of Admission					
Ward Type: General	<input type="checkbox"/>	Private*	<input type="checkbox"/>	Semi-Private*	<input type="checkbox"/>
* To be charged and paid for privately (if available)					

### Patient Medical Aid Details

Medical Aid/Medical Insurance			
Medical Aid Number/Policy No.			
<b>Plan / Option</b>			
Dependant Code (Patient)		Waiting Period (Patient)	
Authorisation No.		Benefit Date	

Medical aid membership card and ID document must be produced on admission

### Main Member

Title				Surname			
First Name(s)				Relationship to Patient			
ID / Passport No			Date of Birth		Age		
Nationality			Language		Religion		
<b>E-mail Address</b>						Vehicle Reg. No.	
Home Tel No			Cellphone No.				
<b>Physical Address*</b>		Unit No.	Complex Name				
Street No.		Street Name					
Suburb/District			City/Town		Post Code		
<b>Postal Address*</b>		Post Box/Private Bag					
Suburb/District			Country		Post Code		
<b>Employment Information</b>							
Name of Company					Occupation		
Employee No.			Period of Employment				
<b>Physical Work Address</b>		Unit No.	Complex/Building Name				
Street No.		Street Name					
Suburb/District			City/Town		Post Code		
<b>Work E-mail Address</b>						Work Tel No.	

### Guarantor (other than the patient or main member)

Title				Surname			
First Name(s)				Relationship to Patient			
ID / Passport No			Date of Birth		Age		
Nationality			Language		Religion		
<b>E-mail Address</b>						Vehicle Reg. No.	
Home Tel No			Cellphone No.				
<b>Physical Address*</b>		Unit No.	Complex Name				
Street No.		Street Name					
Suburb/District			City/Town		Post Code		
<b>Postal Address*</b>		Post Box/Private Bag					
Suburb/District			Country		Post Code		
<b>Employment Information</b>							
Name of Company					Occupation		
Employee No.			Period of Employment				
<b>Physical Work Address</b>		Unit No.	Complex/Building Name				
Street No.		Street Name					
Suburb/District			City/Town		Post Code		
<b>Work E-mail Address</b>						Work Tel No.	

\* In the case of non-South African resident, the guarantor's residential address and contact telephone numbers in South Africa and country of origin must be provided. I, the undersigned, hereby confirm that Netcare may use the email addresses as indicated in the patient/guarantor details for communication purposes on accounts and invoices.

Please tick  applicable box

PATIENT       GUARANTOR

PARENT(S) or GUARDIAN(S) (if minor child)

(Full name[s])

(Signature[s])

### Injury on Duty / WCA Details

1. **WCL2 AND WCL4 and certified ID documents must be provided to the hospital.**
2. **Re-opening approval letter for cases older than 2 years from date of accident must be provided to hospital.**

## Terms and Conditions

The Guarantor	Means any person who signs these terms and conditions, independently from the patient, parent(s) or guardian, and who accepts full responsibility for payment of Netcare's invoice. The Guarantor remains liable for full outstanding balance/s, unless settled in full by the patient, parent/guardian, main member, medical aid or any other party.
Netcare	Means Netcare Hospitals (Pty) Ltd, its holding, subsidiary and associated companies and all of those companies' directors, officers, employees and/or agents, as well as any hospital, clinic or medical facility owned and/or operated by Netcare.
Signatories	Includes the patient, guarantor, parent(s) and guardian where the patient is a minor, together or separately where the person has signed in that capacity.
Third Parties	"Third parties", include but are not limited to medical practitioners, doctor's, radiologists, physiotherapists, pathologists, specialists, medical aid and other service providers who are not employed by Netcare but are involved in the provision of various services to the patient.
Payment of account	I/we, the undersigned, will be responsible for and agree to make payment of the Netcare fee (" <b>the fee</b> ") for the use of the Netcare facility and health services rendered, as charged by Netcare from time to time. Details of the fee structure as applicable from time to time are available in writing on request, and form part of this Netcare Contract.
Recovery of costs	In the event where you have failed to pay the fee mentioned above, Netcare have the right to recover any legal costs to recover the amount due. Attorney's fees will be recovered by the attorney directly from you.
Signatories personally responsible	I/we, the undersigned, signatory(ies), will be personally responsible for payment of the fee, whether the invoice has been submitted to my medical scheme or any other party for payment. The person who signed these terms and conditions, as the person responsible for payment of the fee, will remain solely responsible for the full outstanding amount.
Deposit / Guarantee	We, Netcare, may request a deposit or guarantee from you, which must be provided immediately. Acceptable payment methods will be provided to you with the request.
Invoice due and payable	The fee becomes due and payable immediately upon presentation of a final invoice.
Consent to access credit information	I/we, the undersigned, consent to Netcare obtaining from any credit bureau, or any other institution with whom I/we, the undersigned, may have financial dealings any information concerning my credit profile and payment history.
Patient's consent	I acknowledge that in providing health and/or medical services ("Services") to me, it is necessary for Netcare and third parties that are involved in the provision of services, to process my personal information. "I provide my express consent to Netcare to process my personal information as defined in legislation for purposes of providing service and to share such personal information with "third parties" in order to provide various medical and related services to me".
Consent to Magistrates Court	I/we, the undersigned, hereby consent and submit in terms of section 45 of the Magistrates' Courts Act to the jurisdiction Jurisdiction of the appropriate Magistrate's Court in respect of all actions or other proceedings which might be brought against me/us by or on behalf of Netcare arising out of my/our failure to pay the fee or other breach of the Netcare Contract, irrespective of the value of the claim against me/us.
South African Jurisdiction and Law	This Netcare Contract and the use of Netcare Facility and any health services provided by Netcare to the patient shall be governed by and construed in accordance with the laws of the Republic of South Africa.
Address for Notices	The addresses provided in the details section above are the chosen addresses for all purposes, including the serving of any court documents such as summonses or notices, the payment of any amount and any communication between the parties in terms of this agreement. A party may change their chosen address by 30 days written notice to the other party.
Verification of Address & Employment	Netcare reserves the right to verify address and employment details.
Notice	Every notice, consent, invoice or other communication required or permitted in terms of this contract, must be in writing. Notices may be delivered: <ul style="list-style-type: none"> <li>• by hand to the address referred to in the details section or any other address chosen in writing;</li> <li>• by telefax or e-mail to the addressee's telefax number or e-mail address, an acknowledgement of receipt from the recipient must be given to the sender;</li> </ul> <p style="text-align: center;"><b>or</b></p> <ul style="list-style-type: none"> <li>• by prepaid registered post to the address referred to in the details section or any other address chosen in writing.</li> </ul>
Disclosure	I/we, the undersigned, authorises Netcare, or any attending doctor, or any other attending healthcare professional to disclose the nature of the patient's diagnosis and/or any health services rendered to the patient and all and any records or copies of records in relation thereto to the patient's medical aid.
Medical Practitioners	I/we, the undersigned, understand and accept that the medical practitioners, doctors, radiologists, physiotherapists, specialists and other such practitioners who treat the patient are independent contractors who are not employed by Netcare and that Netcare is not responsible for their invoices or treatment.
Disclaimer in respect of property	I/we, the undersigned, understand, accept and agree that Netcare will <b>not</b> be liable or responsible for <b>any</b> loss of, damage or destruction to, <b>any</b> property, including money and valuables, belonging to the patient, or in possession of the patient, or given to Netcare for safekeeping, even if Netcare is/was negligent in any way and no matter how the loss, damage or destruction was caused.
Minor patients	Where the patient is a minor, that is unmarried and below the age of 18 years, both the minor's parents and/or guardians sign these terms and conditions in both their personal and representative capacities and in so doing accept responsibility for payment of the fee in full.
Accounts and invoices	I/we, the undersigned, hereby confirm that Netcare may use the email addresses as indicated in the patient/guarantor details for communication purposes on accounts and/or invoices. Netcare may use my personal information for purposes of collecting and recovering any amounts owed by myself to Netcare.
Terms and conditions read, understood and agree	I/we, the undersigned, warrant that I/we, the undersigned, have read, understood and agree to these terms and conditions, and the <b>Disclaimer in respect of property</b> set out herein and contracts on such terms, conditions and the <b>Disclaimer in respect of property</b> .

SIGNED AT ..... ON THIS ..... DAY OF ..... 2 .....

**Please tick  applicable box**

**PATIENT**

(Full name[s])

(Signature[s])

**PARENT(S) OR**

**GUARDIAN(S)** (if minor child)

**MAIN MEMBER / GUARANTOR:**  
(where the signatory(ies) is a person other than the patient or the patient's parent(s) and/or guardian(s))

(Full name)

(Signature)

**NETCARE STAFF MEMBER:**

(Full name)

(Signature)



Patient Sticker

### INJURY QUESTIONNAIRE

Dear Sir/Madam

To enable your scheme to promptly process your claim, please complete **IN FULL**.

1. Date of injury .....

Place: Home  School  Work  Motor Vehicle/Bicycle accident  Other.....

2. Specify **ALL** the injuries sustained:

.....  
.....

3. In your own words, explain how the injury occurred:

.....  
.....  
.....  
.....  
.....  
.....

**PLEASE CIRCLE THE CORRECT OPTION:**

1) In case of injury whilst on duty:  
Was the injury reported to your Employer? YES/ NO  
Name of Person at Employer \_\_\_\_\_  
If NO, please state reason:

.....  
.....

2) In case of a Motor Vehicle or Motorcycle accident (your medical scheme may request additional documentation, which will remain your responsibility to complete and provide to your scheme):  
Were you the driver of the vehicle? YES / NO  
Will you claim from Road Accident Fund? YES / NO

I declare that the answers given are to the best of my knowledge, true and correct.

**PATIENT SIGNATURE**.....

**DATE**..... **TEL. NO.**.....

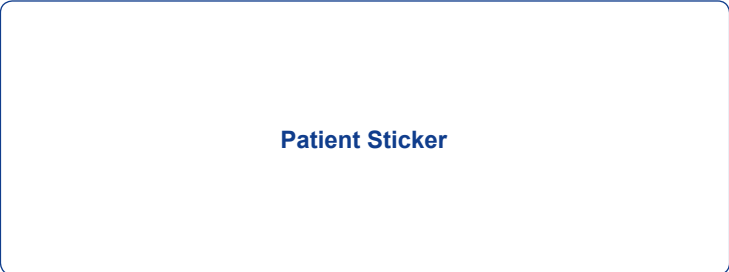
**Office Use Only: Hospital Admission Clerk to complete  
(for accurate coding purposes)**

<b>TRANSPORT SPECIFIC tick off where applicable</b>	
Pedestrian	
Driver	
Passenger	
<b> </b>	
In collision with Another vehicle	
Non collision transport accident	
<b> </b>	
Pedal Cyclist	
Motor Cyclist	
Off road vehicle [Exp. Quad bike]	
Car / Motor vehicle	
Pick up truck / Van / "Bakkie"	
Bus [Including Taxis]	
Heavy Transport vehicle	
Three wheeler	
Animal	
Aircraft	
Water transport	
Other specified	
Unspecified transport	

<b>ACTIVITY (as per coding rules) tick where applicable</b>		
<b>0</b>	While engaged in sports activity	
<b>1</b>	While engaged in leisure activity	
<b>2</b>	While working for income	
<b>3</b>	While engaged in other types of work	
<b>4</b>	While resting, sleeping, eating or other vital activities	
<b>8</b>	While engaged in other specified activities	
<b>9</b>	During unspecified activity	

<b>PLACE OF OCCURRENCE (as per coding rules) tick off where applicable</b>		
<b>0</b>	Home	
<b>1</b>	Residential area	
<b>2</b>	School / Institute / Public administrative area	
<b>3</b>	Sport and athletics area	
<b>4</b>	Street and highway	
<b>5</b>	Trade and service area	
<b>6</b>	Industrial and construction area	
<b>7</b>	Farm	
<b>8</b>	Other specified places	
<b>9</b>	Unspecified place	





Patient Sticker

MEDICAL AID PATIENTS	Checked	Comments	Follow up
POA			
<b>Documentation and Information</b>			
Main Member ID received and scanned (copy)			
Patient ID received and scanned (copy)			
Medical Aid Card received and scanned (copy)			
Admission Hospital Information Document explained and signed			
Admission Terms and Conditions explained and signed			
Injury Report completed and signed (where applicable)			
Baby Registration Document completed and signed (Maternity)			
<b>Confirmation and Validation</b>			
Authorisation Number confirmed			
Valid Membership confirmed (terminated/suspended)			
Co-payments / Deductions confirmed			
Benefit Date checked (members less than 1 year risk)			
Waiting Period confirmed (where applicable)			
Exclusions for Admission confirmed			
Annual Hospital Limit checked (where applicable)			
Pro-rate Limit checked (where applicable)			
Prosthesis Limit checked			
Orthopaedic Limit checked			
Procedure Limit checked			
Dental Limit checked			
Oncology Limit checked			
Vascular Limit checked			
Psychiatric Limit checked			
Maternity Limit checked			
Guarantor Physical Work Address completed			
Work Confirmation of Guarantor done			

WCA PATIENTS (INJURY ON DUTY)	Checked	Comments	Follow up
<b>Compensation Commissioner</b>			
Patient Valid ID received and scanned (copy)			
W.C.L. 2 (Employer's Report) received and scanned (copy)			
W.C.L. 4 (First Medical Report) received and scanned (copy)			
Travel Questionnaire received (MVA cases)			
Assault Questionnaire received (where applicable)			
Re-opening Letter received (cases older than 2 years)			
<b>Exempted Employers</b>			
Correctional Service Members: G111 (valid 6 months)			
Rand Mutual Members: Claim No./Authorisation Letter received			
City of Tswane: Incident Report (replace W.C.L. 2)			

RISK	Checked	Comments	Follow up
Risk Identified			
Communicated to Patient / Guarantor			
Emailed / Communicated to Risk Chain			
Escalated for Management			
Scratch Entries Performed			

Pre-admissions Clerk \_\_\_\_\_ Date \_\_\_\_\_

Receptionist Clerk \_\_\_\_\_ Date \_\_\_\_\_

Followed up by \_\_\_\_\_ Date \_\_\_\_\_

**Accuracy Check**

<b>All Admissions (from ID/Passport Document)</b>	<b>Correct</b>	<b>Incorrect</b>	<b>Resolved</b>
Patient Surname and Initials			
ID Number			
Date of Birth			
Main Member Surname and Initials			
ID Number			
Date of Birth			
<b>Medical Aid Patients (from M/Aid Card)</b>	<b>Correct</b>	<b>Incorrect</b>	<b>Resolved</b>
Medical Aid Name			
Medical Aid Option / Plan			
Medical Aid Number			
Patient Dependent Code			
Authorisation Number			
<b>WCA Patients (WCL2 Document)</b>	<b>Correct</b>	<b>Incorrect</b>	<b>Resolved</b>
Signed by Authorised Person			
Company Name Correct and Complete			
Registration Number Complete / Accurate			
Date of Accident: Ensure within 2 years			
Item 37: In connection with Trade or Business			
Item 38: Clear description of Accident			
Item 41: Employer Satisfied			

Reviewer Name and Surname: .....

Date: .....