




Network Option

Summary Claims Statement Explained

SAMPLE PAGE: 01



11 SEPTEMBER 2020 **1**

12345678
MRS J SAMPLE
8 WORKERS LANE **2**
JOHANNESBURG
2001

3 Member number
12345678

4 Group/Employer number
987654321

Practice number

5 Statement number 24 of 2020 **5**

6 Our reference number
43215678

SUMMARY CLAIMS STATEMENT

Option: Network Option **7**

8 Payment made 9	Paid this month 10	Paid year to date
Major Medical/Day-to-Day benefit	416.00	416.00
Chronic Medication	164.55	164.55
11 Total payments made	580.55	580.55

12 Benefit	Annual allowance 13	Less: Claims paid year to date 14	Benefit Available 15
Prosthesis Internal			
Dependant 0	0.00	0.00	0.00
Dependant 1	0.00	0.00	0.00
Chronic Medication - Non-PMB			
Dependant 0	0.00	0.00	0.00
Dependant 1	0.00	0.00	0.00
Prosthesis External			
Dependant 0	0.00	0.00	0.00
Dependant 1	0.00	0.00	0.00
Specialist			
Dependant 0	0.00	0.00	0.00
Dependant 1	0.00	0.00	0.00
Emergency visits/outpatients			
Per family	0.00	0.00	0.00

16 Messages

Important messages from the Fund or the Administrator.

WOOLTRU HEALTHCARE FUND

Parc du Cap, 7 Mispel Road, Bellville 7530 PO Box 2212, Bellville 7535
Telephone 0802 228 922 Fax 0860 104 126
Registered in terms of the Medical Schemes Act, 1998

SUMMARY CLAIMS STATEMENT

- 1** **DATE OF STATEMENT:** This is the date that the statement is generated.
- 2** **PRINCIPAL MEMBER NAME AND ADDRESS:** This reflects the name and address of the principal member.
- 3** **MEMBERSHIP NUMBER:** This is your Wooltru Healthcare Fund membership number.
- 4** **GROUP/EMPLOYER NUMBER:** This number reflects your employer number.
- 5** **STATEMENT NUMBER:** This is the number of the statement that has been generated.
- 6** **OUR REFERENCE NUMBER:** This is the Administrator's reference number which you need to quote in all correspondence and when calling in with queries.



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SUMMARY CLAIMS STATEMENT CONTINUED

- 7** **OPTION:** This reflects which benefit option of the Fund you are on.
- 8** **PAYMENT MADE:** This lists payments made to which benefit.
- 9** **PAID THIS MONTH:** This lists payments that have been made so far this month per benefit.
- 10** **PAID YEAR TO DATE:** This shows payments that have been made so far this year per benefit.
- 11** **TOTAL PAYMENTS MADE:** Total payments made this month and this year.
- 12** **BENEFIT:** This indicates the benefits available.
- 13** **ANNUAL ALLOWANCE:** This indicates sub-limits available.
- 14** **LESS: CLAIMS PAID YEAR TO DATE:** This indicates payments that have been made for the year per benefit.
- 15** **BENEFIT AVAILABLE:** Indicates the balance of the benefit left for the year.
- 16** **MESSAGES:** This will reflect any important messages from the Fund or the Administrator.

DETAILED CLAIMS STATEMENT

1 Option: NETWORK OPTION

MRS J SAMPLE 3

2 Date: 11 September 2020

Member Number: 12345678 4

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5 Details of your claims transactions				10 Payment information							
6 Date of service	7 Patient	8 Tariff	9 Amount claimed	11 Amount paid to provider	12 Amount paid to member	13 Member paid/owes provider	14 Payment process date (see below*)	15 Major medical/Day-to-day benefits	16 Chronic medication benefit - PMB	17 Chronic medication benefit - Non-PMB	18 Pay code (see**)
19 DR J SMITH (PRACTICE NUMBER 123456)											
2020/08/09	Jane	190	416.00	0.00	416.00	0.00	2020/09/11	416.00	0.00	0.00	26
Totals			416.00	0.00	416.00	0.00		416.00	0.00	0.00	
ANON PHARMACY (PRACTICE NUMBER 654321)											
2020/08/01	John	Chronic	164.55	164.55	0.00	0.00	2020/09/11	0.00	164.55	0.00	
Totals			164.55	164.55	0.00	0.00		0.00	164.55	0.00	
Totals			580.55	164.55	416.00	0.00		416.00	164.55	0.00	

DISCLAIMER: All balances are correct as at the time of printing this statement.

21 * Note that money will be paid into members' bank accounts within +/- five working days of the claims payment process date.

22 ** Pay code Explanation
26 Claim paid to member due to fees charged above Fund rates. Member to pay provider in full.

DETAILED CLAIMS STATEMENT

- 1 **OPTION:** This reflects which benefit option of the Fund you are on.
- 2 **DATE OF STATEMENT:** This is the date that the statement is generated.
- 3 **MEMBER NAME:** The name of the principal member.
- 4 **MEMBERSHIP NUMBER:** This is your Wooltru Healthcare Fund membership number.
- 5 **DETAILS OF YOUR CLAIMS TRANSACTIONS:** This explains the claims that have been submitted in more detail.
- 6 **DATE OF SERVICE:** The date that you visited the doctor/provider.
- 7 **PATIENT:** The name of the patient/dependant.
- 8 **TARIFF:** This is the code that the doctor/provider uses to charge for services rendered.
- 9 **AMOUNT CLAIMED:** The amount that the doctor/provider has billed for services rendered.
- 10 **PAYMENT INFORMATION:** This explains how the claim is processed and paid.
- 11 **AMOUNT PAID TO PROVIDER:** The amount paid to the provider by the Fund.
- 12 **AMOUNT PAID TO MEMBER:** The amount that has been paid directly to the member.
- 13 **MEMBER PAID/OWES PROVIDER:** This shows the amount you have paid upfront to the provider, or if you owe any balance on this claim.
- 14 **PAYMENT PROCESS DATE:** The date the money should reflect into the banking account of the provider.
- 15 **MAJOR MEDICAL/DAY-TO-DAY BENEFIT:** This shows which benefit the claim will be paid from.
- 16 **CHRONIC MEDICATION BENEFIT - PMB:** This section shows a PMB chronic medication claim.
- 17 **CHRONIC MEDICATION BENEFIT - NON-PMB:** This shows a non-PMB chronic medication claim.
- 18 **PAY CODE:** The explanation that goes along with the claim.
- 19 **DETAILS OF YOUR CLAIMS TRANSACTIONS:** This shows the details of the claims, i.e. provider, tariff, amount charged, etc.
- 20 **TOTALS:** This reflects the total amounts paid out following the claims payment run.
- 21 **NOTES:** Any notes from the Fund or Administrator pertaining to these claims will be explained here.
- 22 **PAY CODE EXPLANATION:** This shows any further detail related to the claim that needs clarity.

DETAILED CLAIMS STATEMENT

1 Option: NETWORK OPTION

MRS J SAMPLE 3

2 Date: 11 September 2020

Member Number: 12345678

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