

# TRANSPORT ASSISTANCE PLAN CLAIM FORM



Tel: +264 83 2999 000

E-mail copy of completed form to: [rma@prosperitynam.com](mailto:rma@prosperitynam.com)

Kindly do not use Tippex in the completion of this form - kindly initial where corrections have been made and complete accordingly.

## Section A - Principal Member Details

Member Number																	
Name & Surname																	
Date of Birth	D	D	M	M	Y	Y	Y	Y	Date Joined	D	D	M	M	Y	Y	Y	Y
Postal Address																	
Telephone Number							Cellphone Number										
Fax Number							E-mail Address										

## Section B - Patient Details

Name & Surname														
Date of Birth	D	D	M	M	Y	Y	Y	Y						

## Section C - Treating Healthcare Professional Details (Healthcare Professional referral letter must be attached.)

Initials & Surname													
Speciality													
Practice Number													
Postal Address													
Telephone Number													
Fax Number													

## Section D - Healthcare Professional Referral Details

Specialist Initials & Surname																	
Practice Number																	
Patient Name																	
Diagnosis																	
Referral Date	D	D	M	M	Y	Y	Y	Y	Appointment Date	D	D	M	M	Y	Y	Y	Y

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## Section E - Travel & Accommodation Details

Bus ticket		Air Ticket		Petrol Slips		Kindly attach proof of transport used and receipts						
Travel Date	D	D	M	M	Y	Y	Y	Y				
Accommodation Name							Kindly attach proof of accommodation					
Invoice attached	Yes			No								
Accommodation Date	D	D	M	M	Y	Y	Y	Y				
Claim amount for Travel Expenses	N\$						Claim amount for Accommodation Expenses	N\$				

## Section F - For Office Use

Approved						Date Approved	D	D	M	M	Y	Y	Y	Y
Not Approved						Date Disapproved	D	D	M	M	Y	Y	Y	Y
Administrator														