

## CLAIM FORM

<b>SURNAME</b>	<b>INITIALS</b>	<b>DATE</b>	<b>CHANGE OF ADDRESS</b> Please complete only if address has changed
<b>MEMBERSHIP NUMBER</b>	<b>FUND NAME</b>		

## CLAIM DETAILS

Please attach supporting documents

PATIENT	PAYABLE TO		Name of Supplier	Amount
First Name	Member	Supplier		
<b>TOTAL</b>				

**Note: Only claim forms signed and presented to Pharos Medical Plan<sup>TM</sup>, by a valid member, will be processed.**

I hereby certify that the above claims are bona fide, true and correct.

MEMBER SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_