

The Anglo American Corporation  
 Medical Aid Society  
 2nd Floor, Zimnat House  
 86 Nelson Mandela Avenue / Third St  
 Box UA 130, Union Avenue  
 HARARE, ZIMBABWE  
 Email: aacmas@sovhealth.co.zw



Administered by:  
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**NOTIFICATION FORM**

To be used for notification of Insured Benefits. Benefits requiring notification are hospitalisation, day surgery, MRI scans, CT scans, Bone Densitometry scans, and maternity.

**(CONFIDENTIAL)**

**MEMBER DETAILS**

Title:  Mr  Mrs  Miss  Ms      Membership number: \_\_\_\_\_

Surname:	First Name(s):
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**PATIENT DETAILS**

Surname:	First Name(s):
Date of birth:	AACMAS Membership Number & Suffix:

**TYPE OF NOTIFICATION (Please complete the appropriate section)**

**1 HOSPITALISATION ( INCLUDING DAY SURGERY )**

✓ To be notified before admission or within 2 days of admission.

Admitting Hospital	Date of admission	Attending Doctor	Diagnosis/Nature of illness	Expected duration of stay	Comments

**2 MATERNITY NOTIFICATION**

✓ Please notify on confirmation of pregnancy.

✓ Separate notification for admission to deliver.

Attending General Practitioner or Specialist	Referring Doctor (if being attended to by a Specialist)	Expected Date of delivery	Maternity Scans done by	Comments

**3 MRI SCAN, CT SCAN, OR BONE DENSITOMETRY SCAN**

✓ Notification required before scanning.

Scanning Facility/ Radiologist	Date of scan	Referring Doctor	Diagnosis/Nature of illness	Comments

**4 EMERGENCY ROOMS VISIT**

✓ Notify within 2 days of visit.

✓ Award from insured benefits subject to Fund's approval.

✓ Non-emergencies paid for from Medical Savings Account.

Emergency Rooms Visited	Date of treatment	Attending Doctor	Diagnosis/Nature of illness	Comments

**FOR SOVEREIGN USE ONLY**

DATE RECEIVED:	ACTIONED BY:
NOTIFICATION NUMBER:	COMMENTS: