SERVICE PROVIDER QUERY FORM

GENERAL INFORMATION

SCHEME NAME			
SERVICE PROVIDER NAME			
PRACTICE NAME			
EMAIL		MOBILE	

PATIENT/MEMBER INFORMATION

MEMBER/PATIENT FULL NAMES	MEMBERSHIP NUMBER	SERVICE DATE	CLAIMED AMOUNT	PAID AMOUNT	REJECTED TARRIF CODE	REJECTION REASON (AS PER SHSB PORTAL)	SHSB FEEDBACK

SHSB INTERNAL

RESOLUTION CLOSED ☐ ESCALATED ☐ ONGOING ☐

NOTES

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