REGULAR FORCE
MEDICAL CONTINUATION FUND

PPS Centurion Square
Cnr Heuwel Avenue and Gordon Hood Road
Centurion
0157
PO Box 3799, Pretoria 0001

TRAVEL CLAIM REIMBURSEMENT FORM

Dear Beneficiary

In order for the RFMCF to evaluate your travel claim, we would need the following documents to be emailed to finance@rfmcf.co.za:

1. Please complete the Travel Claim Reimbursement Form **in full**.
2. Proof of admission/hospitalisation of the person into a hospital.
3. If traveling by ambulance, public or via a private transportation service, proof of the transportation invoice (transportation service purchased by the VPA Member) must be provided.

*Note: Travel arrangements must be made by the VPA Member (family or friends if need be).

***Note*: Travel Claim reimbursement is only applicable as stipulated in the SANDF General Regulations, Part IV: RFMCF of Chapter XV: Medical Matters, Regulation 24 (Rights, privileges and duties in respect of the Fund) 8. a & b, which reads:**

(8) (a) Whenever the Surgeon-General deems it necessary, in respect of the admission or future admission of a person to a hospital in terms of subregulation (2) and the person's medical condition makes him or her unfit to provide his or her own transport, the Surgeon-General may authorise the transportation of such person to and from hospital in an ambulance or any Government or public transport and for this purpose authorise the issue authority for the most economical method of transport against repayment: Provided that authorisation for the use of private transport, where Government or public transport is not available or feasible, may be granted by the Manager of the Fund on a standing authorisation of the Surgeon-General;

(b) the Fund must pay for the use of any transport authorised in terms of subparagraph (a) according to –

(i) the tariffs laid down by Treasury for Government transport;
(ii) the public tariffs laid down in respect of transport by rail or by air; and
(iii) the tariffs applicable to any other form of transport, as the case may be.

Declaration by Treating Clinician:

I, Doctor, Name & Surname: _____

Force Number/ID Number: _____

Practice Number: _____

hereby declare that this patient is unfit* to travel on his/her own means and would require transportation to and from hospital in an ambulance, public or via a private transport service.

_____ _____

(**Signature of Treating Clinician**) **Date**

* *A patient is considered unfit for travel when their medical condition poses a significant risk to their health or safety during the journey. This determination is typically made by a healthcare professional, taking into account various factors such as the patient's overall health, the nature and severity of their condition, the duration and mode of travel, and the availability of appropriate medical care en route. Unfitness for travel may be due to acute illnesses, exacerbation of chronic conditions, recent surgeries, or other medical reasons that could compromise the patient's ability to endure the physical stresses of travel.*

Travel Claim reimbursement submitted by

VPA Number	
Member Name/Surname	
Cell Phone Number	
Email Address	

Travel Destination

Sr No	**Destination From** Indicate the location from where you are traveling	**Destination To** Indicate the location to where you are traveling	**Distance in Kilometers**
01			
02			
03			
04			

* *Note: The cheapest bus quote tariff will be used as a reimbursement tariff in the event that a private transportation service was utilised.*

Patient Details

Provide the patient and hospital admission and discharge information in the table below:

VPA Number	**Patient Full Names**	**Date Admitted in Hospital**	**Date Discharged from Hospital**

Bank Details

Only the principal member's bank account details are allowed for reimbursement.

Kindly supply a letter from the bank or a bank statement to confirm the bank details.

Bank		**Branch**	
Account Holder		**Type of Account**	
Account Number			

If any of the above-mentioned requirements are incomplete or found to be inaccurate, the claim will not be processed.

_____ _____

RFMCF Member's Signature Date