Retail Medical Scheme

Administered by Discovery Health

Contact details
Tel: 0860 101 252 • PO Box 652509, Benmore 2010 • www.retailmedicalscheme.co.za

Request for additional cover for out-of-hospital Prescribed Minimum Benefit conditions

Who we are

Retail Medical Scheme registration number 1176 (referred to as 'the Scheme'), is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). Discovery Health (Pty) Ltd administers Retail Medical Scheme

The latest version of this application form is available on www.retailmedicalscheme.co.za. Alternatively, you can call 0860 101 252 or your doctor can call 0860 44 55 66 for us to send the latest form.

About this form

This form should be completed when you need out-of-hospital treatment that falls outside of the basic level of care provided for in the Prescribed Minimum Benefits.

Please only complete this form if we have already reviewed a request for funding for your condition as a Prescribed Minimum Benefit.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. You need to complete sections 1 and 2 of this form.
3. Your doctor must complete sections 3 and 4 and include detailed documents to support this application for acute and/or ongoing treatment for a Prescribed Minimum Benefit.
4. Please fax this completed and signed form with any supporting documents to 011 539 2780 or email it to PMB_APP_FORMS@discovery.co.za
5. You will receive a letter informing you of our decision and the process you should follow for claims submissions.
6. You may call us if you would like to dispute a declined decision.

1. Patient details

Name and surname

Date of birth (D D M M Y Y Y Y) Identity number

Membership number

Telephone (H) (W)

Cellphone Fax

Email address

The outcome of this application can be communicated to me via Email ☐ Fax ☐

2. Member undertakings

I give permission for my doctor to provide Retail Medical Scheme with my diagnosis and other relevant clinical information required to review my application for Prescribed Minimum Benefits. I consent to Retail Medical Scheme and Discovery Health (Pty) Ltd disclosing from time to time, information supplied to Retail Medical Scheme and Discovery Health (Pty) Ltd (including general or medical information that is relevant to my application) to my doctor, to administer my benefits. I agree that Retail Medical Scheme may disclose this information at its discretion but only as long as all the parties involved have agreed to always keep the information confidential.

I understand that:

1. Funding from the Prescribed Minimum Benefit is subject to meeting benefit entry requirements.
2. Each case will be assessed on its own merit.
3. By registering for the Prescribed Minimum Benefits, I agree that my condition may be subject to disease management interventions and periodic review and this may include review of my medical records.
4. Treatment approved as a Prescribed Minimum Benefit will only be effective from when Retail Medical Scheme receives an application form that is completed in full.

5. The covered Prescribed Minimum Benefit conditions and benefit entry requirements may change from time to time and I may need to send an updated or new application form if Retail Medical Scheme asks for this.
6. Consent for processing my personal information
   6.1. I give the Scheme and Administrator consent to have access to and process all information (including general, personal, medical or clinical information) that is relevant to this application.
   6.2. I understand that this information will be used for the purposes of applying for and assessing my funding request for Prescribed Minimum Benefits.
   6.3. I consent to the Scheme and Administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical information) to my healthcare provider, to administer the Prescribed Minimum Benefits.

Patient's signature

Date D D M M Y Y Y Y

(if patient is a minor, main member to sign)

I acknowledge that I have read and understood the conditions under "Member undertakings" (section 2).

3. Application (healthcare professional to complete)

3.1. Application for out-of-hospital treatment*

Condition	ICD-10 Code	Consultation or procedure code**	Consultation or procedure description	Quantity required

*Please clearly specify what is required, for example consultations, pathology, radiology and/or procedure.
**The professional billing codes must be supplied for us to review the application.

Please attach any relevant supporting documentation, for example pathology tests. If the application is for psychotherapy treatment for members younger than 13 years of age, the scheme will require the latest DSM V form including the GAF (Global assessment of Functioning) score.

3.2. Application for medicine

Current medicine required (please provide supportive clinical results or information, where necessary)

Condition	ICD-10 code	Medicine name, strength and dosage	How long has the patient used this medicine?	
			Years	Months

3.3. Application for radiology

Condition	ICD-10 code	Procedure code	Procedure description	Quantity required

3.4. Application for pathology

Condition	ICD-10 code	Procedure code	Procedure description	Quantity required

4. Healthcare Professional's details

Name and surname

BHF practice number

Speciality

Telephone

Fax number

Email address

Outcome of this application must be sent to me via Email Fax

Notes to Healthcare Professional

4.1. Please ensure that the relevant ICD-10 diagnosis code(s) are used when you submit your claims to the Scheme to ensure payment from the correct benefit.

4.2. Please include the ICD-10 diagnosis code(s) when referring your patient to the pathologists and/or radiologists. This will enable the pathologists and radiologists to include this information on their claims and allow us to comply with legislation by paying Prescribed Minimum Benefits (PMB) claims correctly.

4.3. We will approve funding for generic medicine, where available, unless you have indicated otherwise.

4.4. Please submit all the requested supporting documents with this application to prevent delays in the review process.

4.5. Should you make changes to your patient's treatment plan, you need to let us know so that we can update their PMB authorisation/s. You can do this by emailing the new prescription to us. If you or your patient do not let us know about changes to the treatment plan, we may not pay claims from the correct benefit.

Healthcare professional's signature

Date D D M M Y Y Y Y