



Contact details

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

### Application for additional allied, therapeutic and psychology benefits for 2024

#### **Retail Essential Plus Option**

#### Please use this form when a member needs cover for additional treatment sessions.

This application form is for members on the Retail Essential Plus Option to apply for additional allied, therapeutic and psychology benefits.

#### Who we are

Retail Medical Scheme (referred to as "the Scheme"), registration number 1176, 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.

#### How to complete this form

- 1. Please use one letter per block, complete in black ink and print clearly and remember to sign the form.
- 2. You (the member) must complete section 1 and 2 of this form.
- 3. Your Healthcare professionals must complete sections 5 to 11.
- 4. All relevant sections must be physically signed by the applicant and cannot be signed digitally. The applicant must sign and date any changes.
- 5. Please fax the completed and signed form to 011 539 2860 or email it to ATmotivations@discovery.co.za.

Please note: Due to confidentiality, the patient's name is excluded, however, please make sure that you include the patient's date of birth.

1. Patient informat	ion (to	be o	com	plete	d by	the p	atie	nt)														
Title					Initi	als																
Surname																						
First name(s) (as per identity document)																						
Membership number																						
ID or passport number																						
Telephone (H)												Telephon	e (W)									
Phone Number													Fax									
Email address																						
Relationship to main me	ember																					
Signature of patient														[	Date	D	M	M	Υ	Υ	Υ	Υ
	(if pa	tient i	sam	inor, r	nain m	embe	r or g	uard	ian to	sigr	)											

Please note that funding for additional healthcare services will be effective from when Retail Medical Scheme receives a completed, signed form.

We will send you communication about the funding decision within 7 working days from receiving the completed form.

I acknowledge that I have read and understood the conditions for additional benefits under "Important information" (Section 3), on page 2.

#### 2. Details of all healthcare professionals you currently visit

## 2.1. List all healthcare professionals not included in the application form (for example: GPs, specialists, other allied, therapeutic and psychology professionals)

Name	Discipline
2.2. Current medicine the patient is on, relevant to the primary dia	agnosis

#### 3. Important information

I give permission for my healthcare professional to provide Retail Medical Scheme with my diagnosis and other relevant clinical information required to review my application for additional allied, therapeutic and psychology benefits.

I understand that:

- 1. Funding for additional allied, therapeutic and psychology services is subject to meeting benefit entry requirements as determined by Retail Medical Scheme.
- 2. Funding for additional allied, therapeutic and psychology services will only be effective once I have reached the annual allied, therapeutic and psychology benefit limit applicable on my benefit option.
- 3. The outcome of the decision will be sent via email to the members email address as listed on our records.
- 4. Only services from acousticians, biokineticists, chiropractors, occupational therapists, physiotherapists, psychologists, social workers (in mental health) and speech-language therapists and audiologists will be considered for funding.
- 5. We will not consider cover for both a chiropractor and physiotherapist for the same condition.
- 6. We will not consider cover for both a psychologist and a social worker for the same condition.
- 7. Retail Medical Scheme will pay the claims for the approved additional allied, therapeutic and psychology healthcare services from the available funds in my Medical Savings Account according to the benefit option I selected. Once I reach the Above Threshold Benefit, all of the approved allied, therapeutic and psychology claims will pay at 100% of the Scheme Rate.
- 8. My application for additional allied, therapeutic and psychology benefits will only be reviewed when Retail Medical Scheme receives an application form that is completed in full.
- 9. Funding for additional healthcare services will be effective from when Retail Medical Scheme receives a completed, signed form.
- 10. The approved additional allied, therapeutic and psychology benefits only applies for the dependant whose name is on the application form.
- 11. I may need to send an updated or new application form, if required by Retail Medical Scheme or its clinical advisory panels.
- 12. By requesting additional allied, therapeutic and psychology benefits, I agree that my condition may be subject to benefit parameters and guidelines as determined by the relevant professional body, disease management interventions and periodic review for clinical evidence and cost-effectiveness. I understand that these processes may require access to my medical records and if I do not give consent for this access, this may lead to the withdrawal of this benefit.
- 13. I consent to Retail Medical Scheme disclosing, from time to time, information supplied to Retail Medical Scheme (including general or medical information that is relevant to my application) to my healthcare professional, to administer the additional allied, therapeutic and psychology 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.
- 14. As a healthcare funder, the administrator funds treatments related to medical or clinical needs. When a medical scheme member applies for funding for additional allied, therapeutic and psychology benefits after they reached their annual family limit for the year, it is important to note that the additional benefit does not include therapies related to disorders of a scholastic nature (educational), including but not limited to school readiness testing. The additional benefit for allied, therapeutic and psychology services is not designed to fund any conditions of a non-clinical or non-medical nature. If the therapy is clinically indicated, we will require supporting information for retrospective review.
- 15. Assessments are not considered for funding through this application process, they are funded from day to day benefits subject to the annual family Allied, Therapeutic and Psychology Benefit limit.

#### 4. Notes to healthcare professional

- 1. The healthcare professional's fee for completion of this form will be reimbursed as per their relevant report writing billing code and/or billing guidelines, on submission of a separate claim. Payment of the claim is from the day-to-day benefits (if applicable to the member's benefit option), subject to Scheme rules and availability of funds and where the member is a valid and active member at the service date of the claim.
- 2. In line with legislative requirements, please ensure that when using your report writing billing code, you submit the ICD-10 diagnosis code(s). As per industry standards, the appropriate ICD-10 code(s) to use for this purpose would be those reflective of the actual condition(s) for which the form was completed. If funding for multiple conditions is applied for, then it would be appropriate to list all the relevant ICD-10 codes.
- 3. I understand that panel members from the relevant advisory panel will review the information I provide by completing this form as well as the motivation I attach. This information will form part of the final recommendation and funding decision as communicated to the patient on the completion of this application process.
- 4. We will not consider cover for both a chiropractor and physiotherapist for the same condition.
- 5. We will not consider cover for both a psychologist and a social worker for the same condition.
- 6. As a healthcare funder, Retail Medical Scheme funds treatments related to medical or clinical needs. When a medical scheme member applies for funding for additional allied, therapeutic and psychology benefits after they reached their annual family limit for the year, it is important to note that the additional benefit does not include therapies related to disorders of a scholastic nature (educational), including but not limited to school readiness testing. The additional benefit for allied, therapeutic and psychology services is not designed to fund any conditions of a non-clinical or non-medical nature. If the therapy is clinically indicated, we will require supporting information for retrospective review.
- 7. Funding for additional healthcare services will be effective from when administrator receives a completed, signed form. Failure to complete all relevant information under each section can result in the application being sent back for further completion, as to ensure the review process can take place.
- 8. Assessments are not considered for funding through this application process, they are funded from day to day benefits subject to the annual family Allied, Therapeutic and Psychology Benefit limit.

lamily Amed, Therape	and and regionology					
5. Biokineticist sect	ion					
Please note: Due to co	nfidentiality the pa	atient's name is excluded,	but please make sure th	nat you include the pa	atient's date of	f birth.
Please note: This section	on is only to be comp	pleted by the treating healt	hcare provider. If not, th	ne form won't be acce	epted.	
Membership number		Patient	age Pa	tient date of birth	D M M Y	Y Y Y
Healthcare professional r	name and surname					
BHF practice number						
Special interest						
Telephone (W)				Fax		
Email address						
acknowledge that I ha	ave read and unde	erstood the conditions fo	r additional benefits	as mentioned in se	ction 4 on pag	ge 2.
				L	L. L. L. L.	
Healthcare professional's	signature			Date	Y Y Y M	I M D D
5.1. Information about	the nationt's cond	lition				
5.1.1 Diagnosis details	-					
Please specify detailed	Description		Date and nature of in	cident / onset	Dur	ation
ICD code(s)						
					< 12 weeks	> 12 weeks
<b>5.1.2.</b> If your patient has the Healthcare Professio	_	ion, please complete and a	ttach the relevant Bioki	netic spinal evaluatio	n form which c	an be found or
the Healthcare Professio	nal Zone at www.dis					an be found on
the Healthcare Professio	nal Zone at www.dis	scovery.co.za	hcare provider. If not, th	ne form won't be acce	epted.	
the Healthcare Professio	nal Zone at www.dis	scovery.co.za pleted by the treating healt	hcare provider. If not, th	ne form won't be acce	epted.	

		esent treatment required referr	J									
Consucode(s	ultation or procedure s)	Length of sessions (minutes)	Number of treatments required per week or month	Number of the remain to comple	ndei	of t	he c	curre	ent b	enef		ar
	- decement on to also were		maler in									
	Number of sessions use	hat phase the member is curre	nuy m.									
Year		ons (excluding additional benef	it sessions that were approved	)				A	pplic	ed fo	or ben	efi
2016									Yes		No	
2017									Yes		No	
2018									Yes		No	
2019									Yes		No	
2020									Yes		No	
2021									Yes		No	
2022									Yes		No	
2023									Yes		No	
Amour	nt of additional funding sea	ssions awarded in the previous be	nefit year:									
Amou	ınt of additional benefit	sessions awarded										
	al start date of therapy:				D	D	М	M	Y	Υ		Υ
	date of therapy in current				D	D	M	M	Y	Y		Y
	ate of therapy in current y				D	D	M	M	Y	Υ	Υ	Y
Total r	number of sessions and fr	requency in current year:										
5.2.2 [ used)	Description of past treat	tment sessions to date, of abov	re mentioned ICD-10 code (Plea	se also ind	icat	e the	e pr	осе	dure	e co	des	
5.2.3 N	Motivation for treatmen	t for above mentioned ICD-10 c	ode									
	Motivation for treatment to d		ode									
			ode									
			ode									
			ode									
Include		ate on functionality	ode									
Include	e impact of treatment to d	ate on functionality	ode									

5.2.5 Relevant patient		-	ational	امدم	coo:	ial fo	ınotic	ni∽	a	rov.	0110	troot-	nont	hoon	italia	atio-	, hi	otor	v 0*	nrim	.O	dica	ınaa:	ic			
Include previous diagno	ses, 00	cupa	auonai	and	SOCI	iai IU	ITICTIO	nin	g, pi	revi	ous	ueatr	nent,	поѕр	nialis	allor	ı, nı	sior	y of	prim	iary	uiag	mosi	1 <b>5</b>			
6. Chiropractor sec																											
Please note: Due to co	onfide	ntial	ity the	pati	ent's	s nai	me is	ex			but	pleas	e ma	ke sı							atie	nt's	date	of b	oirth.	Iv	ly
Membership number									Title	е					Pa	tient	dat	e of	bir	th		IVI	IVI				
Healthcare professional	name	and s	surnan	ne		ı																					
BHF practice number																											
Special interest										_																	
Telephone																Fax	κ										
Email																											
I acknowledge that I h	ave re	ead a	nd un	ders	stoo	d th	e co	ndi	ition	is f	or a	dditio	onal b	bene	fits	as m	ent	ion	ed i	in se	ctio	n 4	on	page	∌ 2.		
																			Dat	te	D	M	M	Υ	Υ	Υ	Υ
Healthcare professional	's signa	ature																									
																_											
6.1. Information about		atien	t's co	ndit	ion																						
6.1.1. Diagnosis details			D	! 4!											-4:-		- 4 / -		_	<b></b>							
Please specify detailed ICD code(s)			Desc	cripti	on						D	ate a	nd na	iture	or in	ciaer	π / α	onse	et  L	Jurai	ion						
											+								+								
																			_								
																			_								
C. 2. Information about				-4	4		:l																				
6.2. Information about			1					nut	.00/		NI	umbe	or of t	rootm	onto	rogi	uiroc	1		Jumk	or o	of tot	ol or	occie		.001	uirod
Consultation or procedu	ire cod	ie(S)	Leng	jtri Oi	ses	Sion	is (mi	nuı	.es)				er of to ek or			requ	uirec	ı	f	or the enef	e rer	nain	der	of th	e cu	rrer	
																				liagn			J COI	пріс	ile C	une	71 IL

C 2 4	Mirro	L 4	f sessions	
D.Z.1	. Num	per o	rsessions	usea

Year	Total amount of sessions (excluding additional benefit sessions that were approved)				A a	pp dd	lie itio	d fo nal	r be	nef
2016						,	Yes		N	0
2017						,	Yes		N	0
2018						,	Yes		N	0
2019							Yes		N	0
2020							Yes		N	0
2021						,	Yes		N	0
2022						_	Yes		N	0
2023						,	Yes		N	0
	t of additional funding sessions awarded in the previous benefit year:  nt of additional benefit sessions awarded									
	al start date of therapy:	D	D	M	M		Y	Y	Υ	Y
	late of therapy in current year:	D	D	M	M	_	Y	Y	Υ	Y
	ate of therapy in current year:	D	D	M	M		Y	Υ	Υ	Y
Total n	number of sessions and frequency in current year:									
	Motivation for treatment nclude impact of treatment to date on functionality									
.2.4. (	Goals of further treatment sessions									

6.2.5. Relevant patient h	nistor	у																										
Include previous di	agnos	ses, (	occu	ıpati	onal	land	d so	cial t	fund	ction	ning	, pre	vious	s treat	men	t, ho	spita	alisat	tion	, his	tory	of p	rima	ary c	liagr	nosi	S	
7. Occupational ther	anisi	t sec	ctio	n																								
Please note: Due to cor					atie	nt's i	nam	ne is	exc	clude	ed,	but p	oleas	e mal	ke sı	ıre th	nat y	ou ir	nclu	ıde t	he p	atie	ent's	dat	e of	birth	١.	
Membership number												t age	1					date				D	M	M	Υ	Υ	Υ	Υ
Healthcare professional n	ame a	and s	surna	ame																								
BHF practice number																												
Special interest																												
Telephone (W)																	Fa	x										
Email address																												
I acknowledge that I ha	ve re	ad a	nd ı	und	erst	ood	the	COI	ndi	tion	s fo	or ac	ditio	nal b	ene	fits a	as m	ent	ion	ed i	n se	ectic	on 4	on	pag	je 2.		
Healthcare professional's	signa	ture																		Dat	е	D	M	M	Y	Y	Y	Y
7.1. Information about t	he pa	atien	t's (	cond	ditio	n																						
7.1.1. Diagnosis details																												
Please specify detailed	D	escr	iptic	n											Da	ite ar	nd n	ature	e of	inci	den	t / o	nset	:				
ICD code(s)																												
															'													
7.2. Information about t																												
Consultation or procedure code(s)	Э	L	.eng	th of	ses	sion	ıs (n	ninu	tes)	)				reatm mont		requ	iired									quire bene		r
, ,											ľ															gnos		

## 7.2.1. Number of sessions used Total amount of sessions (excluding additional benefit sessions that were approved) Applied for additional benefit 2016 Yes No 2017 No Yes 2018 Yes No 2019 No Yes 2020 Yes No 2021 Yes No 2022 No Yes 2023 Yes No Amount of additional funding sessions awarded in the previous benefit year: Amount of additional benefit sessions awarded Original start date of therapy: Start date of therapy in current year: Last date of therapy in current year: Total number of sessions and frequency in current year: 7.3 Brief summary of occupational therapy to date 7.4 Motivation for treatment Include impact of treatment to date on functionality 7.5. Detailed goals for future therapy

# 7.6 Brief history of patient's pre-morbid functioning and relevant patient history

7.7 Motivation for treatment of adults - Please include additional motivation with this application including:

Information about assistance required for participation in activities of daily living, functional transfers and upper limb function, cognitive and/or perceptual function, and pre-morbid work/school/university history.

Please note: Standardised tests and scores should be indicated in reports when formal testing was included in the assessment.

#### 7.8 Motivation for treatment of children - Please include additional motivation with this application including:

Information about impact on development, behaviour, school and social functioning, as well as relevant birth and background history. Please note: Standard scores should be indicated in reports when formal testing was included in the assessment.

Please include additional assessment and progress reports to this application for paediatric cases.

8. Physioth	erapist section								
Please note:	Due to confidentia	ality the patient's	name is excluded	but please r	make sure tha	t you include	e the patient's	date of birt	h.
Membership n	umber		Patie	nt age	Patie	ent date of b	irth D D M	M Y Y	Y
Healthcare pro	ofessional name and	surname							
BHF practice r	number								
Special interes	st								
Telephone (W)						Fax			
Email address									
I acknowledg	e that I have read	and understood	the conditions f	or additiona	al benefits as	mentioned	l in section 4	on page 2	
Healthcare pro	ofessional's signature	е				D	ate D D M	M Y Y	Y
8.1. Informati	on about the patie	nt's condition							
8.1.1. Diagno	sis details								
Please specific ICD code(s)	y detailed	Description		Date and	nature of inci	dent / onset	Duration		
.02 0000(0)							< 12 weeks	> 12 w	veeks
8.2. Informati	ion about the pres	ent treatment re	quired				1		
Consultation of code(s)	or procedure	Length of session		umber of trea er week or m	atments requir onth	the rer	er of total sessi mainder of the o complete curr	current ber	nefit
8.2.1. Number	r of sessions used					·			
Year Total a	amount of session	s (excluding add	litional benefit se	ssions that	were approv	red)		Applied f	or al benefit
2016								Yes	No
2017								Yes	No
2018								Yes	No
2019								Yes	No
2020								Yes	No
2021								Yes	No
2022								Yes	No
2023								Yes	No
Amount of add	ditional funding sessi	ons awarded in th	ne previous benefit	year:					

Amount of additional benefit sessions awarded									
Original start date of therapy:		)	D N	1	M	Υ	Υ	Υ	Y
Start date of therapy in current year:		)	D N	1	M	Υ	Υ	Υ	Υ
Last date of therapy in current year:		)	D N	1	M	Υ	Υ	Υ	Υ
Total number of sessions and frequency in current year:									
8.2.2 Description of past treatment sessions to date (Please also indicate the procedure codes u	sed)								
8.2.3 Motivation for treatment									
Include outcome measures used and scores/impact of treatment to date on functionality									
9.2.4 Cools of further treatment coosings									
8.2.4 Goals of further treatment sessions									
8.2.5 Relevant patient history									
Include previous diagnoses, occupational and social functioning, previous treatment, hospitalisation, birtl primary diagnosis.	h history	m	ilesto	nes	s an	d his	story	y of	
pilinary diagnosis.									
9. Psychologist section									
Please note: Due to confidentiality the patient's name is excluded, but please make sure that you inc			tient'	s d	ate	of b	irth.	·	lv I
Membership number Patient age	Date		D IV		IVI	Y	Ť	Ĭ,	Ĭ .
Healthcare professional name and surname									
BHF practice number									
Tick the relevant box: Are you a Clinical psychologist Counselling psychologist	Edu	cat	ional	ps	ych	olog	ist		
Special interest									
Telephone (W)									
Email									
I acknowledge that I have read and understood the conditions for additional benefits as mentic	ned in	sec	tion	4 c	n p	age	2.		
	Date		D M	1	M	Υ	Υ	Υ	Υ
Healthcare professional's signature	2010							1	

# 9.1. Information about the patient's condition 9.1.1. Diagnosis details Please specify Description Date and nature of incident / onset detailed ICD code(s) 9.1.2. Multi-axial diagnosis: Please give a DSM-V diagnosis Current GAF and/or GARF DSM-V Pre-treatment GAF and/or GARF Additional/supporting comments about diagnosis, including impact on social and occupational/scholastic functioning (If a paediatric assessment has been done, please include/attach report recommendations): 9.1.3. Relevant patient history (Include previous diagnoses, occupational and social functioning, previous treatment, hospitalisation, history of primary diagnosis) Please also indicate the procedure codes used. 9.1.3.1. Previous diagnosis 9.1.3.2. Current symptom presentations

9.1.3.3. Occupational and social functioning

RMSAAA001

J. 1.J.4	. Previous treatment											
9.1.3.5	i. Hospitalisation											
9.1.3.6	i. History of primary diagno	sis (including a description	on of stressors for trauma and stressor-	relate	d di	isor	der	s)				
044	N											
Year	Number of sessions used  Total amount of sessions	(excluding additional ber	nefit sessions that were approved)					Αn	nlie	d fo	r	
	Total amount of doctorio	(exercianing dualities as								onal		efit
2016									Yes	;	No	
2017									Yes	;	No	
2018									Yes	,	No	
2019									Yes	•	No	
2020									Yes	•	No	
2021									Yes		No	
2022									Yes		No	
2023									Yes		No	
										<u>'</u>		
Amour	nt of additional funding session	ns awarded in the previous	benefit year:									
	ınt of additional benefit ses		<u> </u>									
Origin	al start date of therapy:				D	D	M	M	Υ	Υ	Υ	Υ
Start o	date of therapy in current year	r:			D	D	M	M	Υ	Υ	Υ	Υ
Last d	ate of therapy in current year	:			D	D	M	M	Υ	Υ	Υ	Υ
Total	number of sessions and frequen	ency in current year:					ì	Ì	Ť	Ť		
9.2 Inf	ormation about the treatme	ent required										
Consu	ultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	for be	the	ren t ye	nain ar to	der	of th	ons r ne cu ete c	ırren	t

9.2.1. Indicate method	(s) of 1	treatm	ent a	nd tre	eatme	nt to	dat	e		
9.2.2. Treatment to dat	te inclu	uding	additi	onal	sessi	ons i	n th	ера	ast three years	
Indicate impact of development, beha								atio	nal functioning. For children, i	include information about impact on
9.2.3. Motivation for a	dditior	al tro	atmor	<b></b>						
3.2.3. Wottvation for a	aditioi	iai ti C								
9.2.4 If you are treatin consideration	g mult	iple m	embe	ers of	the s	ame	fam	ily,	please motivate and give cl	ear reasons, as this might pose an ethical
10. Social Worker (a	additio	onal r	nenta	al hea	althc	are l	oene	efit	s)	
Confirm that you mee	t the c	riteria	(as d	letern	nined	in c	ollab	bora		Social Worker in mental healthcare overy.co.za
Membership number									Patient age	Date $\square$
Healthcare professional	name a	and su	rname							
BHF practice number										
Special interest									_	
Telephone (W)										

Email						
I ackno	wledge that I have read and u	nderstood the conditions f	or additional benefits a	s mentioned in section 4	on page 2	2.
Healthc	are professional's signature			Date D M	M Y Y	Y
10.1. In	formation about the patient's c	condition				
	Diagnosis details					
Please ICD co	specify detailed de(s)	Description		Date and nature of incider	nt / onset	
10.1.2.	Multi-axial diagnosis: Please g	give a DSM-V diagnosis				
Current GAF and/or GARF			DSM-V			
Pre-tre	atment GAF and/or GARF					
1 10 110	attion of analog of the					
Ple	Relevant patient history Include previous diagnoses, occuease also indicate the procedure Number of sessions used	upational and social functioning codes used.	ng, previous treatment, ho	ospitalisation, history of prin	nary diagno	osis)
	Total amount of sessions (excl	luding additional benefit se	ssions that were appro	ved)	Applied f	
2016					additiona Yes	No No
2017					Yes	No
2018					Yes	No
2019					Yes	No
2020					Yes	No
2021					Yes	No
2022					Yes	No
2023					Yes	No

Amount of additional funding session	ns awarded in the previous benefi	it year.								
Amount of additional benefit ses	ssions awarded									
Original start date of therapy:			D	D	M	M	Υ	Υ	Υ	Y
Start date of therapy in current year:			D	D	M	M	Y	Υ	Y	Y
Last date of therapy in current year:			D	D	M	M	Y	Y	Y	Y
Total number of sessions and frequency in current year:								T		<u> </u>
10.2 Information about the treatr	ment required			·		<u> </u>	-			
Consultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	for the	mainder of the current benefit						
10.2.1. Indicate method(s) of trea	atment and treatment to date									
10.2.2. Treatment to date includir occupational functioning. For children	ng additional sessions in the pen, include information about imp	ast three years (Indicate impact of to act on development, behaviour, school	reatment ol and so	to d cial	ate (	on so	ocial ng.)	and	d	
10.2.3. Motivation for additional	treatment									

11. Speech-language therapis	t and aud	liologist section									
Please note: Due to confidentiality t	the patient's	s name is excluded, but	please make sure that y	ou include t	he patient's da	te of birth	٦.				
Membership number		Patient	age	D	Pate D D M	M Y	Y Y	Y			
Healthcare professional name and su	ırname								Ī		
BHF practice number											
Special interest											
Telephone (W)			Fax						Ī		
Email									Ī		
I acknowledge that I have read an	d underst	ood the conditions for	additional benefits as	s mentioned	d in section 4	on page	2.				
Healthcare professional's signature				D	M Y	Y	Y				
11.1. Information about the patient	t's condition	on		1							
11.1.1. Diagnosis details											
Please specify detailed ICD code(s)		Description		Date and r	nature of incid	dent / onset					
100 0000(0)								_			
									_		
									_		
									_		
									_		
11.2 Information about the treatme	ent require	ed							_		
	Length of s	essions	Number of treatments r	equired		er of total sessions required					
	(minutes)			for the remainder of t	of the current benefit						
					year to complete curr	ent diagr	nosis				
									_		
			1		1				_		
11.2.1. Number of sessions used											
Year Total amount of sessions (	excluding	additional benefit sess	sions that were approv	ved)		Applied addition		enefi	t		
2016						Yes		No			
2017						Yes	1	No			
2018						Yes	1	No			
2019						Yes	<b>N</b>	No			
2020						Yes		No			
2021						Yes		No	I		
2022						Yes		No			
2023						Yes	1	No.	Ī		

Amount of additional funding sessions awarded in the previous benefit year:								
Amount of additional benefit sessions awarded								
Original start date of therapy:	D	D	M	M	Υ	Υ	Υ	Υ
Start date of therapy in current year:	D	D	M	M	Y	Υ	Υ	Υ
Last date of therapy in current year:	D	D	M	M	Υ	Υ	Υ	Υ
Total number of sessions and frequency in current year:		İ		Ī	Ī			
11.2.2 Description of past treatment sessions to date								
11.2.3. Motivation for additional treatment (Include impact of treatment to date on functionality)								
11.2.4 Goals of further treatment sessions								
11.2.4 Godis of futurer treatment sessions								
11.2.5 Relevant patient history Description of past treatment sessions to date (Please also indicate the procedure codes used)								