Retail Medical Scheme

Administered by Discovery Health

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 information (to be completed by the patient)

Title		Initials	
Surname			
First name(s) (as per identity document)			
Membership number			
ID or passport number			
Telephone (H)		Telephone (W)	
Phone Number		Fax	
Email address			
Relationship to main member			
Signature of patient		Date	D D M M Y Y Y Y

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

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 diagnosis**

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.

5. Biokineticist section

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

Please note: This section is only to be completed by the treating healthcare provider. If not, the form won't be accepted.

Membership number | Patient age | Patient date of birth (D D M M Y Y Y Y)

Healthcare professional name and surname

BHF practice number

Special interest

Telephone (W) | Fax

Email address

I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.

Healthcare professional's signature

Date (Y Y Y Y M M D D)

5.1. Information about the patient's condition

5.1.1. Diagnosis details of current diagnosis

Please specify detailed ICD code(s)	Description	Date and nature of incident / onset	Duration	
			< 12 weeks	> 12 weeks

5.1.2. If your patient has the following condition, please complete and attach the relevant Biokinetic spinal evaluation form which can be found on the Healthcare Professional Zone at www.discovery.co.za

Please note: This section is only to be completed by the treating healthcare provider. If not, the form won't be accepted.

Condition	Attached Biokinetic spinal evaluation form (available on the Healthcare Professional Zone on the website)
Cervical	Yes ☐ No ☐
Lumbar spine	Yes ☐ No ☐

5.2. Information about the present treatment required referring to the above ICD-10 code

Consultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year to complete current diagnosis

Attach description to show what phase the member is currently in.

5.2.1. Number of sessions used

Year	Total amount of sessions (excluding additional benefit sessions that were approved)	Applied for additional 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 additional funding sessions awarded in the previous benefit year:

Amount of additional benefit sessions awarded	
Original start date of therapy:	D D M M Y Y Y Y
Start date of therapy in current year:	D D M M Y Y 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:	

5.2.2 Description of past treatment sessions to date, of above mentioned ICD-10 code (Please also indicate the procedure codes used)

5.2.3 Motivation for treatment for above mentioned ICD-10 code

Include impact of treatment to date on functionality

5.2.4 Goals for further treatment sessions

5.2.5 Relevant patient history

Include previous diagnoses, occupational and social functioning, previous treatment, hospitalisation, history of primary diagnosis

6. Chiropractor section

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

Membership number | Title | Patient date of birth (D D M M Y Y Y Y)

Healthcare professional name and surname

BHF practice number

Special interest

Telephone | Fax

Email

I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.

Healthcare professional's signature | Date (D D M M Y Y Y Y)

6.1. Information about the patient's condition

6.1.1. Diagnosis details

Please specify detailed ICD code(s)	Description	Date and nature of incident / onset	Duration

6.2. Information about the present treatment required

Consultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year to complete current diagnosis

6.2.1. Number of sessions used

Year	Total amount of sessions (excluding additional benefit sessions that were approved)	Applied for additional 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 additional funding sessions awarded in the previous benefit year:

Amount of additional benefit sessions awarded	
Original start date of therapy:	D D M M Y Y Y Y
Start date of therapy in current year:	D D M M Y Y 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:	

6.2.2. Brief summary of occupational therapy to date (Please also indicate the procedure codes used)

6.2.3. Motivation for treatment

Include impact of treatment to date on functionality

6.2.4. Goals of further treatment sessions

6.2.5. Relevant patient history

Include previous diagnoses, occupational and social functioning, previous treatment, hospitalisation, history of primary diagnosis

7. Occupational therapist section

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

Membership number | Patient age | Patient date of birth (D D M M Y Y Y Y)

Healthcare professional name and surname

BHF practice number

Special interest

Telephone (W) | Fax

Email address

I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.

Healthcare professional's signature

Date (D D M M Y Y Y Y)

7.1. Information about the patient's condition

7.1.1. Diagnosis details

Please specify detailed ICD code(s)	Description	Date and nature of incident / onset

7.2. Information about the present treatment required

Consultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year to complete current diagnosis

7.2.1. Number of sessions used

Year	Total amount of sessions (excluding additional benefit sessions that were approved)	Applied for additional 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 additional funding sessions awarded in the previous benefit year:

Amount of additional benefit sessions awarded	
Original start date of therapy:	D D M M Y Y Y Y
Start date of therapy in current year:	D D M M Y Y 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:	

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. Physiotherapist section

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

Membership number | Patient age | Patient date of birth (D D M M Y Y Y Y)

Healthcare professional name and surname

BHF practice number

Special interest

Telephone (W) | Fax

Email address

I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.

Healthcare professional's signature | Date (D D M M Y Y Y Y)

8.1. Information about the patient's condition

8.1.1. Diagnosis details

Please specify detailed ICD code(s)	Description	Date and nature of incident / onset	Duration	
			< 12 weeks	> 12 weeks

8.2. Information about the present treatment required

Consultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year to complete current diagnosis

8.2.1. Number of sessions used

Year	Total amount of sessions (excluding additional benefit sessions that were approved)	Applied for additional 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 additional funding sessions awarded in the previous benefit year:

Amount of additional benefit sessions awarded	
Original start date of therapy:	D D M M Y Y Y Y
Start date of therapy in current year:	D D M M Y Y 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:	

8.2.2 Description of past treatment sessions to date (Please also indicate the procedure codes used)

8.2.3 Motivation for treatment

Include outcome measures used and scores/impact of treatment to date on functionality

8.2.4 Goals of further treatment sessions

8.2.5 Relevant patient history

Include previous diagnoses, occupational and social functioning, previous treatment, hospitalisation, birth history, milestones and history of primary diagnosis.

9. Psychologist section

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

Membership number | Patient age | Date D D M M Y Y Y Y

Healthcare professional name and surname

BHF practice number

Tick the relevant box: Are you a ☐ Clinical psychologist ☐ Counselling psychologist ☐ Educational psychologist

Special interest

Telephone (W) | Fax

Email

I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.

Healthcare professional's signature | Date D D M M Y Y Y Y

9.1. Information about the patient's condition

9.1.1. Diagnosis details

Please specify detailed ICD code(s)	Description	Date and nature of incident / onset

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

9.1.3.4. Previous treatment

9.1.3.5. Hospitalisation

9.1.3.6. History of primary diagnosis (including a description of stressors for trauma and stressor-related disorders)

9.1.4. Number of sessions used

Year	Total amount of sessions (excluding additional benefit sessions that were approved)	Applied for additional 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 additional funding sessions awarded in the previous benefit year:

Amount of additional benefit sessions awarded	
Original start date of therapy:	D D M M Y Y Y Y
Start date of therapy in current year:	D D M M Y Y 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:	

9.2 Information about the treatment required

Consultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year to complete current diagnosis

9.2.1. Indicate method(s) of treatment and treatment to date

9.2.2. Treatment to date including additional sessions in the past three years

Indicate impact of treatment to date on social and occupational functioning. For children, include information about impact on development, behaviour, school and social functioning.)

9.2.3. Motivation for additional treatment

9.2.4 If you are treating multiple members of the same family, please motivate and give clear reasons, as this might pose an ethical consideration

10. Social Worker (additional mental healthcare benefits)

Confirm that you meet the criteria (as determined in collaboration with SAASWIP) for the Social Worker in mental healthcare network, when completing the below. Criteria to join the network available on www.discovery.co.za

Membership number Patient age Date D D M M Y Y Y Y

Healthcare professional name and surname

BHF practice number

Special interest

Telephone (W)

Email

I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.

Healthcare professional's signature

Date D D M M Y Y Y Y

10.1. Information about the patient's condition

10.1.1. Diagnosis details

Please specify detailed ICD code(s)	Description	Date and nature of incident / onset

10.1.2. 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:

10.1.3. Relevant patient history

Include previous diagnoses, occupational and social functioning, previous treatment, hospitalisation, history of primary diagnosis) Please also indicate the procedure codes used.

10.1.4. Number of sessions used

Year	Total amount of sessions (excluding additional benefit sessions that were approved)	Applied for additional 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 additional funding sessions awarded in the previous benefit year:

Amount of additional benefit sessions awarded	
Original start date of therapy:	D D M M Y Y Y Y
Start date of therapy in current year:	D D M M Y Y 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:	

10.2 Information about the treatment required

Consultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year

10.2.1. Indicate method(s) of treatment and treatment to date

10.2.2. Treatment to date including additional sessions in the past three years (Indicate impact of treatment to date on social and occupational functioning. For children, include information about impact on development, behaviour, school and social functioning.)

10.2.3. Motivation for additional treatment

11. Speech-language therapist and audiologist section

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

Membership number Patient age Date D D M M Y Y Y Y

Healthcare professional name and surname

BHF practice number

Special interest

Telephone (W) Fax

Email

I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.

Healthcare professional's signature Date D D M M Y Y Y Y

11.1. Information about the patient's condition

11.1.1. Diagnosis details

Please specify detailed ICD code(s)	Description	**Date and nature of incident / onset**

11.2 Information about the treatment required

Consultation or procedure code/s	Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year to complete current diagnosis

11.2.1. Number of sessions used

Year	**Total amount of sessions (excluding additional benefit sessions that were approved)**	**Applied for additional 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 additional funding sessions awarded in the previous benefit year:

Amount of additional benefit sessions awarded	
Original start date of therapy:	D D M M Y Y Y Y
Start date of therapy in current year:	D D M M Y Y 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:	

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

11.2.5 Relevant patient history
Description of past treatment sessions to date (Please also indicate the procedure codes used)