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 HIV Prescribed Minimum Benefits

Request for extra cover from the Prescribed Minimum Benefits (PMB)

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.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. Please complete this form if you wish to apply for additional cover for the diagnosis of, medicine for, or out-of-hospital management of HIV. Please ensure that all the relevant information required, as set out in the form is completed, including contact details for the provider and date of request.
3. You (the patient) must complete Section 1 of this form.
4. Your doctor must complete Section 2 and Section 3, and include detailed documents supporting your application.

Application Process

1. Please email this completed and signed form with any supporting documentation to **HIV_Diseasemanagement@retailmedicalscheme.co.za** or post it to Retail Medical Scheme, PO Box 536, Rivonia 2128.
2. A dedicated case manager will call you and your treating doctor to let you know about our funding decision and the process to follow if your application is approved.
3. You can also contact our call centre on **0860 101 252** if you have any questions.

1. Main member details

Membership number

ID or passport number

Member's name

Member's surname

2. Patient details

Title | Initials

Surname

First name(s)

Membership number | ID or passport number

Telephone (H) | Telephone (W)

Cellphone

Email

Relationship to main member

Patient's signature | Date D D M M Y Y Y Y

(if patient is a minor, parent/guardian to sign)

3. Information about treatment request *(doctor to complete)*

3.1. Application for out-of-hospital medical management

Condition	Consultation and procedure code	Motivation and number of extra medicines and dosages

3.2. Application for medicine

Request for the current medicine (please provide details and relevant laboratory tests to show indication for therapy)

Condition	Medicine name, strength and dosage	Motivation and number of extra medicines and dosages

3.3. Previous medicine history

Medicine	Date medicine started	Length of therapy	Side effects experienced*	Lack of efficacy**

** Please provide details and severity.*
*** Please provide details and attach laboratory tests where applicable.*

4. Doctor's details (doctor to complete)

Name and surname

BHF practice number

Telephone number

Email address

Doctor's signature

Date D D M M Y Y Y Y