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

Application for out-of-hospital management of a Prescribed Minimum Benefit condition

The latest version of the application form is available on www.retailmedicalscheme.co.za. Alternatively, you can phone 0860 101 252 and healthcare providers can phone 0860 44 55 66.

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.
2. You (the member) must complete section 1 of this form.
3. Your healthcare provider must complete sections 2 and 3 and include detailed documents to support this application for acute and/or ongoing treatment for a Prescribed Minimum Benefit.
4. Please email this completed and signed form with any supporting documents to **PMB_APP_FORMS@retailmedicalscheme.co.za**.
5. You will receive a letter informing you of our decision and the process you should follow for claims submission.

1. Important patient information

Title		Initials	
Surname			
First name(s)			
ID or passport number			
Telephone (H)		Telephone (W)	
Cellphone			
Email			

Acceptance and permission

I give permission for my healthcare provider 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 healthcare provider, 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 benefit entry criteria as determined by Retail Medical Scheme.
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 periodic review and that this may include access to 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 clinical entry criteria 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.

Consent for processing my personal information

I give the Scheme and the administrator consent to have access to and process all information (including general, personal, medical or clinical information) that is relevant to this application. I understand that this information will be used for the purposes of applying for and assessing my funding request for Prescribed Minimum Benefits (PMBs). I consent to the Scheme and the administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical information) to my healthcare provider and to relevant third parties, to administer the Prescribed Minimum Benefits (PMBs) as well as undertake managed care interventions related to the Prescribed Minimum Benefit (PMB) condition. Withdrawing consent for your general, personal, medical or clinical information to be accessed or shared with relevant third parties, means that you will no longer have access to funding from the applicable disease management benefits. Claims which would usually be funded from the disease management benefits will, once consent is withdrawn, be funded from other available benefits according to the rules of your benefit option. Should you wish to withdraw consent, then please call **0860 101 252**.

Patient's signature

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

Date D D M M Y Y Y Y

2. Application (healthcare provider to complete)

Date of diagnosis D D M M Y Y Y Y

2.1. 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 documents, for example pathology tests.

Applications for psychotherapy:

- If the application is for psychotherapy treatment for members younger than 13 years of age, the Scheme will require the latest Diagnostic and Statistical Manual of Mental Disorders (DSM V) form including the World Health Organisation Disability Assessment Schedule - Children and Youth version (WHODAS-Child) form.
- Date of 1st psychotherapy session D D M M Y Y Y Y
- Internet-based Cognitive Behavioural Therapy (iCBT) has been demonstrated to be a helpful adjunct to treatment for people with Major Depression*. An iCBT course is included in the treatment basket for Major Depression for all members who are 18 years and older. iCBT will be funded as one (1) psychotherapy consultation from the Out-of-Hospital Treatment of a Prescribed Minimum Benefit, where PMB funding is approved.

Please indicate below if you feel that information on iCBT should not be shared with this member

This member should not receive information on iCBT ☐

If no preference is indicated, the member will be given more information on the iCBT course.
*ICD-10 codes: F32.2; F32.3; F32.8; F32.9; F33.0; F33.1; F33.2; F33.3; F33.4; F33.8; F33.9, F34.0; F34.1; F53.1; F53.8; F53.9

2.2. 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

2.3. Application for radiology

Condition	ICD-10 code	Procedure code	Procedure description	Quantity required

2.4. Application for pathology

Condition	ICD-10 code	Procedure code	Procedure description	Quantity required

3. Healthcare provider's details

Name

Practice number

Email address

Healthcare provider's signature

Date D D M M Y Y Y Y