PRESCRIBED MINIMUM BENEFITS (PMBs) APPLICATION

bestMed

Please note: Please do not use this form to apply for chronic medicine

COMPLETION OF THIS FORM

- Bestmed has appointed a Specialist Designated Service Provider (DSP) network for all Prescribed Minimum Benefits (PMBs).
- Members have the choice to voluntarily use non-DSP providers. However, non-DSP providers may charge higher fees or co-payments which would be for your own account.
- PMBs are subject to pre-authorisation and in the case of emergencies the application must be received within 48 hours.
- To avoid administrative delays, please ensure that all sections are completed in full and in the case of pre-authorisation a written quotation must accompany the fully completed PMB application form.
- The application form MUST be completed by the medical practitioner providing or prescribing the treatment/service and be signed by the member.
- Please ensure that all relevant diagnostic/medical reports are included with the completed application form.
- The completed form can be faxed to 012 472 6760 or sent via email to pmb@bestmed.co.za

SECTION A: PATIENT INFORMATION

Title | Initials

Surname

Member number

Date of birth (D D M M Y Y Y Y) | Gender (M / F)

SECTION B: PMB CONDITION APPLIED FOR

ICD-10 code

Description:

SECTION C: ONGOING PMB SERVICES

MEDICINE APPLIED FOR:

Name & strength of medicine	Directions	Quantity per month	How long has the medicine been used	Number of repeats required	Start date of requested authorisation

CONSULTATION AND TREATMENT CODES APPLIED FOR:

NB: List all consultation, radiology, pathology and other treatment codes

Tariff code	Description	Quantity per month	Number of repeats required	Start date of requested authorisation

Patient Name

Surname

Member number

SECTION D: ACUTE OR EVENT SPECIFIC PMB SERVICES

Service date	Tariff code	Tariff charged	Service date	Tariff code	Tariff charged

Confirm billing practice / tariff structure of the practice applying for funding at cost.

Was the patient and / or member / family informed of the fees to be charged?

YES	NO

- If YES, please provide a copy of the signed document/consent.
- If NO, please motivate

SECTION E: MOTIVATION

Please attach copies of blood test results and / or any other relevant diagnostic reports.

SECTION F: DETAILS OF DOCTOR APPLYING FOR BENEFITS

Initials

Surname

Practice number

Speciality

Tel (W)

Fax

Signature of doctor: _____ Date: _____

SECTION G: PATIENT CONSENT

I, (member) acknowledge that I am aware of the tariff structure of the practice, as well as the Bestmed funding guideline for approved services at the Bestmed rate. I choose to make use of this provider

I hereby give permission to the doctor or any other service porvider to state the diagnosis and mention any other information relating to my condition(s) on the form. I understand that this information will remain confidential at all times.

Signature of member: _____ Date: _____