Request for additional cover for out-of-hospital Prescribed Minimum Benefit conditions 2023

Discovery

Who we are

Discovery Health Medical Scheme, registration number 1125, is a not-for-profit organisation registered with the Council for Medical Schemes, and is the medical scheme that you are applying to become a member of.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Discovery Health Medical Scheme and takes care of the administration of your membership.

Contact us

Tel (members): 0860 99 88 77, Tel (health partners): 0860 44 55 66, **www.discovery.co.za**, PO Box 784262, Sandton, 2146, 1 Discovery Place, Sandton, 2196.

Purpose of the form

This form should be completed when a member needs additional out-of-hospital treatment that falls outside of the basic level of care provided for in the Prescribed Minimum Benefits (PMBs).

What you must do

- Fill in the form in black ink and print clearly, or complete the form digitally.
- All relevant sections must be signed by the main applicant and/or doctor. The main applicant and/or doctor must sign and date any changes.
- You need to complete section 1 and 2 of this form.
- Your healthcare professional needs to complete the rest of the form and include detailed documents to support this application.
- Please email this completed and signed form with any supporting documents to **PMB_APP_FORMS@discovery.co.za** or submit your documents electronically on **www.discovery.co.za** under Medical Aid > Get Help > Submit a document and follow the guided steps through our Virtual Agent.
- You will receive an email informing you of our decision and the process you should follow.
- If you would like to lodge a formal dispute to a declined decision and you have escalated your complaints through the relevant channels and are still unsatisfied with the outcome, or if you feel that the Scheme has not abided by its registered Rules or the provisions of the Medical Schemes Act, then you may lodge a dispute in terms of Scheme Rule 27. To do so, you may complete and submit a dispute form accessed from **www.discovery.co.za** > Medical aid > Manage your health plan > Find important documents and certificates.

1. Patient details

Title Initials

First name(s)

Surname

Membership number Date of birth D D M M Y Y Y Y Gender M F

ID or passport number Country of issue

Telephone (H) Telephone (W)

Cellphone Email

2. Note to patient

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.

Signature of patient (if patient is minor, main member to sign) Date D D M M Y Y Y Y

I acknowledge that I have read and understood the conditions under "Notes to patient" (section 2).

⚠ **Please only sign if information is true, complete and correct.**

3. Application (healthcare professional to complete)

Please complete the table below where the request is for further cover or for consultations or procedures not included in the treatment basket.

Date of diagnosis D D M M Y Y Y Y

3.1. Application for out-of-hospital treatment

Condition	ICD-10 code	Consultation or procedure code	Consultation or procedure description	Quantity required	Motivation

The professional billing codes must be supplied for us to review the application.

Please attach any relevant supporting documents, for example pathology tests. 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 Global Assessment of Functioning (GAF) score.

3.2. Application for medicine

Current medicine required (please provide supportive clinical results or information, where necessary)

Condition	ICD-10 code	Medicine name, strength and dosage	Consultation or procedure description	How long has the patient used this medicine?	
				Years	Months

3.3. Application for radiology

Condition	ICD-10 code	Procedure code	Procedure description	Quantity required

1.4 Application for pathology

Condition	ICD-10 code	Procedure code	Procedure description	Quantity required

4. Healthcare professional's details (healthcare professional to complete)

First name(s)

Surname

BHF practice number

Speciality

Telephone

Email

The outcome of this application will be communicated to you by email.

Notes to healthcare professional

1. Please ensure that the relevant ICD-10 diagnosis code(s) are used when you submit your claims to the Scheme to ensure payment from the correct benefit.
2. Please include the ICD-10 diagnosis code(s) when referring your patient to the pathologists and/or radiologists. This will enable the pathologists and radiologists to include this information on their claims and allow us to comply with legislation by paying Prescribed Minimum Benefits (PMBs) claims correctly.
3. We will approve funding for generic medicine, where available, unless you have indicated otherwise.
4. Please submit all the requested supporting documents with this application to prevent delays in the review process.
5. Should you make changes to your patient's treatment plan, you need to let us know so that we can update their Prescribed Minimum Benefits (PMBs) authorisation/s.
   5.1. You can do this by emailing the new prescription to us.
   5.2. If you or your patient do not let us know about changes to the treatment plan, we may not pay claims from the correct benefit.

Signature of healthcare professional

Date D D M M Y Y Y Y

⚠ **Please only sign if information is true, complete and correct.**