Application for registration of medicine: chronic and prescribed minimum benefits (PMB)

medihelp
Medical Aid in Action

Enquiries: 086 0100 678
Postal address: PO Box 26004, ARCADIA, 0007
Email address: medicineapp@medihelp.co.za

Section 1: To be completed by the patient

Details of principal member

Title _____ Identity number | | | | | | | | | | | | | |

Surname _____ Initials _____

Benefit option _____ Membership number | | | | | | | |

Details of patient

Title _____ Identity number | | | | | | | | | | | | | |

Surname _____ Initials _____

Tel number (H) _____ Gender Male | Female

Cell phone number _____ Tel number (W) _____

Email address _____

I understand and declare that my application shall be void should any information supplied by me be false or incomplete. I grant permission to my doctor to state the diagnosis of my medical condition on this form and understand that the information on this application form will remain confidential at all times. I understand that authorisation is subject to clinical entry criteria and algorithms as determined by Medihelp.

Signature of patient *(parent/guardian if minor)* Date y y y y m m d d

Section 2: To be completed by the medical practitioner

Details of medical practitioner

Initials and surname _____

Type of practitioner (e.g. general practitioner) _____

Practice number _____ Tel number _____

Email address _____

I declare that to the best of my knowledge, all the information provided in this application is true and accurate. I acknowledge that Medihelp can only make informed reimbursement decisions if supplied with all relevant information regarding the patient's condition.

Signature Date y y y y m m d d

Surname and initials of principal member _____

Name of patient _____ Membership number | | | | | | | | | |

Section 3: To be completed by the medical practitioner

Instructions:

1. Complete one application form per patient.
2. **Incomplete or old application forms will not be processed. This application form is only valid for 2022.**
3. If the medicine for a **registered condition** changes, a new script and ICD-10 codes must be sent to Medihelp.
4. Post the completed and signed application form to **PO Box 26004, Arcadia, 0007** or email it to **medicineapp@medihelp.co.za**
5. Registration with Medihelp or changes to an authorisation schedule will only be valid from the date of approval. **Authorisation schedules will under no circumstances be backdated.**
6. If you have any enquiries please phone Medihelp's Customer Care centre on **086 0100 678.**
7. The Customer Care centre is available Mondays to Thursdays from 07:00 to 17:00 and Fridays from 08:00 to 16:00.
8. Clinical queries from medical practitioners will be handled from Mondays to Thursdays from 07:30 to 16:00 and Fridays from 8:00 to 16:00. Only queries regarding conditions already registered with Medihelp will be handled telephonically.

Details of medicine

Diagnosis (compulsory)	ICD-10 code (compulsory)	Prescribed medicine and strength	Dosage	Quantity per month	Number of repeats

Please remember to attach the applicable pathology and/or diagnostic reports, as indicated in the list of requirements. Reports must be clear and readable. Please note that approval of medicine is subject to entry criteria and protocols as determined by Medihelp. Please refer to the MedMove! formulary when prescribing medicine for MedMove! members and to the Elect network formulary for MedVital Elect, MedAdd Elect and MedPrime Elect network members.

Name of attending physician _____ Practice number _____

Type of practitioner (e.g. cardiologist) _____

Signature of medical practitioner

Date | | | | | | | | |