

Prescribed Minimum Benefits out-patient application form

Patient name and surname

Membership number

How to complete this application form

1. Please use one letter per block, complete with black ink and print clearly.
2. To avoid administration delays, please make sure this application is completed in full.
3. Please complete this form for cover in respect of out-of-hospital management of a Prescribed Minimum Benefit (PMB) condition.
4. As a member, you need to complete Section 1 of this form.
5. Your doctor must complete Section 2 and Section 3 and include detailed documentation to support your application.
6. Please fax this completed and signed form together with any documentation to support this application to **011 539 2780** or email **PMB_APP_FORMS@discovery.co.za**
7. You will receive a letter informing you of our decision and the process to be followed.

1. About the main member (member to complete)

Title Initials Surname

ID number Date of birth

Membership number

Postal address

Code

Telephone (H) (W)

Cellphone Fax

Email address

May we communicate your confidential information to you via this email address Yes No or fax Yes No

2. About the patient

Title Initials Surname

ID number Date of birth

Telephone (H) (W)

Cellphone Fax

Email address

May we communicate your confidential information to you via this email address Yes No or fax Yes No

Email address

