

Prescribed Minimum Benefits (PMB) Chronic Disease List (CDL) appeal form

Please complete this form if you want to appeal for extra cover for the diagnosis of, medicine for, or out-of-hospital management of a Prescribed Minimum Benefit (PMB) condition

Patient name and surname

Membership number

How to complete this form

- Please use one letter per block, complete with black ink and print clearly.
- Fax the completed and signed form to **011 539 3000** or email it to **applications@discovery.co.za**
- Please attach a copy of the ID documents of your dependant/s. We also accept SA driver's licences, passports and SA birth certificates for children.
- To avoid administration delays, please ensure this application is completed in full by you and your employer.

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

Name of patient or dependant

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

Has your condition been approved on the Chronic Illness Benefit? Yes No

If yes, your doctor must list the condition for which you are approved for in section 2.

2. Appeal (doctor to complete)

2.1 Appeal for out-of-hospital medical management

Condition	NHRPL consultation or procedure code	NHRPL description	Number of consultations or procedures per year

2.2 Appeal for medicine

Request for current medicine requested (please provide details and relevant laboratory tests to show success of therapy example blood pressure reading, HBA1C)

Condition	Medicine name, strength and dosage	Quantity each month	Is the patient controlled? (Please attach relevant details)
1.			
2.			
3.			
4.			
5.			

2.3 Previous medicine history

Date medicine started Y Y Y Y M M D D

Medicine 1 (name)

Duration of therapy

Side effects experienced (please provide details and severity below)

Lack of efficacy (please provide details and attach laboratory test where appropriate)

Date medicine started Y Y Y Y M M D D

Medicine 2 (name)

Duration of therapy

Side effects experienced (please provide details and severity below)

Lack of efficacy (please provide details and attach laboratory test where appropriate)

Date medicine started Y Y Y Y M M D D

Medicine 3 (name)

Duration of therapy

Side effects experienced (please provide details and severity below)

Lack of efficacy (please provide details and attach laboratory test where appropriate)

Date medicine started Y Y Y Y M M D D

Medicine 4 (name)

Duration of therapy

Side effects experienced (please provide details and severity below)

Lack of efficacy (please provide details and attach laboratory test where appropriate)

3. Doctor's details (doctor to complete)

Name

BHF practice number Speciality

Fax

Doctor's signature

Date 2 0 Y Y M M D D