Request for additional cover for Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions registered on the Chronic Illness Benefit (CIB) 2020

Who we are

Discovery Health Medical Scheme (referred to as 'the Scheme'), registration number 1125, is the medical scheme. This is a non-profit organisation registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the administrator') 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 partner): 0860 44 55 66, PO Box 784262, Sandton, 2146, www.discovery.co.za, 1 Discovery Place,Sandton, 2196.

Purpose of the form

This application form is to apply for additional cover for Prescribed Minimum Benefit Chronic Disease List conditions registered on the Chronic Illness Benefit and is only valid for 2020

What you must do

- Fill in the form in black ink and print clearly, or complete the form digitally.
- All relevant sections must be physically signed by the doctor and cannot be signed digitally. The doctor must sign and date any changes.
- Fax the completed and signed form to **011 539 7000** or email it to **CIB_APP_FORMS@discovery.co.za**
- To avoid administrative delays, please ensure this form is completed in full by you and your doctor.

1. Patient details (Main member to complete if patient is a minor)

Title ____ Initials ____ Surname ____

First name(s) (as per identity document) ____

Membership number ____ ID or passport number ____

Telephone (H) ____ - ____ Telephone (W) ____ - ____

Cellphone ____ - ____ Fax ____ - ____

Email ____

The outcome of this application must be sent to me by ☐ Email ☐ Fax

2. Request for additional consultations and procedures (doctor to complete)

Your patient has automatic access to an annual treatment basket containing a limited number of consultations and procedures when approved for a PMB CDL condition. Please complete the table below where the request is for further cover or for consultations or procedures not included in the basket.

Condition	Consultation or procedure code	Number of consultations or procedures required per year	Supporting information for the request

Please note that this form expires on 31/03/2021. Up to date forms are always available on www.discovery.co.za under Medical Aid > Find documents and your certificates.

DHMRAC001

3. Request for cover in full for non-formulary medicine

Please complete the table below where non-formulary medicine is prescribed for the treatment of PMB CDL conditions and the request is for cover without co-payment. Please supply additional information and supporting documentation where appropriate, as to why the formulary medicine cannot be used by the patient, including details of treatment failure or adverse drug reactions where applicable.

Medicine name and strength	Quantity	Supporting information for the request

Previous medicine history

Medicine name and strength	Date treatment with this medicine was initiated	How long did the patient use the medicine for?	Details of treatment failures or adverse drug reactions

4. Doctor's details (doctor to complete)

Full name and surname

Practice number

Speciality

Telephone - Fax -

Email

The outcome of this application can be communicated to me by ☐ Email ☐ Fax

Signature of doctor

Date D D - M M - Y Y Y Y

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

Discovery Health Medical Scheme is a registered medical scheme and regulated by the Council for Medical Schemes (CMS). The CMS contact details are as follows:
Email: complaints@medicalschemes.co.za | Customer Care Centre: 0861 123 267 | Website: www.medicalschemes.co.za

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