Request for extra Prescribed Minimum Benefit (PMB) cover for HIV 2020

Discovery Health Medical Scheme

Who we are

Discovery Health Medical Scheme (referred to as 'the Scheme'), registration number 1125, is the medical scheme that you are applying to become a member of. This is a not-for-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

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

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 patient and/ or doctor and cannot be signed digitally. The patient and/or doctor must sign and date any changes.
- Fax the completed and signed form to **011 539 3151** or email it to **HIV_Diseasemanagement@discovery.co.za**, or post it to PO Box 536, Rivonia, 2128.
- The doctor must complete section 2 and 3, and include detailed documents supporting your application.
- Your doctor will receive a letter about our decision and the process to be followed for approved requests**.**

1. Patient details

When do you want your cover to start? D D - M M - Y Y Y Y

Title | Initials

Surname

First name(s) (as per identity document)

Preferred name | Gender M F

Date of birth D D - M M - Y Y Y Y

ID or passport number

Telephone (H) -

Telephone (W) - | Cellphone -

Fax -

Email

Postal address(Post collected from post box, suite or private bag)

PO Box | Private Bag | Box number

Suite | Postnet Suite | Number

Suburb | Post code

Relationship to principal member

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 HIVCare Programme? ☐ Yes ☐ No

If **yes,** your doctor must list the condition for which you are approved on the next page.

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

2. Application (doctor to complete)

2.1. Application for out-of-hospital medical management

Condition	Consultation or procedure code	Motivation and number of extra consultations or procedures

2.2. Application for medicine

Request for the current medicine(please provide details and relevant laboratory tests to show success of therapy)

Condition	Consultation or procedure code	Motivation and number of extra medicine and dosage

2.3. Previous medicine history

Medicine	Date medicine started	Length of therapy	Side effects experienced*	Lack of efficacy**

** Please provide details and severity*

*** Please provide details and attach laboratory test where appropriate*

3. Doctor's details (doctor to complete)

Full name and surname

BHF Practice number

Speciality

Telephone -

Email (preferred email to receive patient progress reports)

The outcome of this application must be communicated to me through my email address ☐ Yes ☐ No

or Fax number ☐ Yes ☐ No

or telephone number ☐ Yes ☐ No

Signature of doctor

Date D D - M M - Y Y Y Y

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