# Application for additional allied, therapeutic and psychology cover 2021

Executive, Comprehensive and Priority Plans only



#### Who we are

Discovery Health Medical Scheme, registration number 1125, is a not-for-profit organisation registered with the Council for Medical Schemes (CMS), and is the medical scheme that you are a member of.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, 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 partners): 0860 44 55 66, www.discovery.co.za, PO Box 784262, Sandton, 2146,

1 Discovery Place, Sandton, 2196.

## Purpose of the form

This application form is for members on the Executive, Comprehensive and Priority Plan to apply for additional cover for allied, therapeutic and psychology healthcare services above the annual benefit limit for conditions that do not form part of the Allied, Therapeutic and Psychology Extender Benefit. Make reference to the footnote that indicates the expiry date of the form. Download the latest version of all forms from www.discovery.co.za under Medical Aid > Manage your health plan > Find important documents and certificates.

## What you must do

- All relevant sections must be physically signed by the patient and cannot be signed digitally. The patient must sign and date any changes.
- Member must complete section 1 and section 2.
- · Sign section 1 of the application form.
- Read "Important information" section on page 2.
- Take the application form to your healthcare professional to complete the relevant sections.
- Email the completed form to ATmotivations@discovery.co.za, or post it to Discovery Health Medical Scheme, PO Box 784262, Sandton 2146.
- Refer to relevant benefit guide for complete information. Up to date forms are available on www.discovery.co.za under Medical Aid > Manage
  your health plan > Find important documents and certificates.

1. Patient information (to be completed by the patient)									
Title	Surname								
First name(s)									
Gender	M F Identity number								
Member number									
Telephone (H)	Telephone (W)	-							
Cellphone									
Email									
Signature of patient(if paminor, main member or sign)	atient is a guardian to	Date Delta - Media - Yelling Yelling							
sign)									

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I acknowledge that I have read and understood the conditions for additional benefits under "Important information" (Section 3), on page 2.

# 2. Details of healthcare professionals (to be completed by healthcare professional/s)

2.1. List all healthcare professionals not included in the application form (for example: GPs, specialists, other allied, therapeutic and psychology professionals)

Name	Discipline

2.2. Current medicine the patient is on, relevant to the primary diagnosis	
carrott measure and patient to any resonant to and primary alagnosis	

# 3. Important information

I give permission for my healthcare professional to provide Discovery Health Medical Scheme and Discovery Health (Pty) Ltd (as administrator) with my diagnosis and other relevant clinical information required to review my application for additional allied, therapeutic and psychology benefits.

#### I understand that:

- 3.1. Funding for additional allied, therapeutic and psychology services is subject to meeting benefit entry requirements as determined by Discovery Health Medical Scheme.
- 3.2. Funding for additional allied, therapeutic and psychology services will only be effective once I have reached the annual Allied and Therapeutic Benefit limit applicable on my plan type.
- 3.3. The outcome of the decision will be sent via email to the member's email address as listed on our records.
- 3.4. Only services from biokineticists, chiropractors, occupational therapists, physiotherapists, psychologists, social workers (in mental health) and speech and hearing therapists (speech-language therapists and audiologists) will be considered for funding.
- 3.5. Discovery Health Medical Scheme will pay the claims for the approved additional allied, therapeutic and psychology services from the available funds in my Medical Savings Account according to the payment option I selected. Once I reached the Above Threshold Benefit, all of the approved allied, therapeutic and psychology claims will pay at 100% of the Discovery Health Rate.
- 3.6. For Priority Plans, these claims will be subject to the Above Threshold Benefit limit.
- 3.7. Members on the Classic Smart Comprehensive plan, need to reach the Annual Threshold to have cover for day-to-day medical expenses.
- 3.8. Funding for additional healthcare services will be effective from when Discovery Health Medical Scheme receives a completed, signed form.
- 3.9. The approved additional allied, therapeutic and psychology benefits only applies for the dependant whose date of birth is on the application form.
- 3.10. I may need to send an updated or new application form, if required by Discovery Health Medical Scheme or its advisory panels (representatives from the relevant professional body).
- 3.11. Consent for processing my personal information, as per privacy Statement:
  - 3.11.1. I give the Scheme and the administrator consent to have access to and process all information (including general, personal, medical or clinical information) that is relevant to this application.
  - 3.11.2. I understand that this information will be used for the purposes of applying for and assessing my funding request for additional allied, therapeutic and psychology services.
  - 3.11.3. I give permission to the Scheme and the administrator to share my medical and clinical information with the external advisory panel, should they need it.
  - 3.11.4. I consent to the Scheme and the administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical information) to my healthcare provider, to administer the additional allied, therapeutic and psychology benefits.

## 4. Notes to healthcare professional

- 4.1. The healthcare professional's fee for completion of this form will be reimbursed as per their relevant report writing billing code and/or billing guidelines, on submission of a separate claim. Payment of the claim is from the day-to-day benefits (if applicable to the member's plan type), subject to Discovery Health Medical Scheme rules and availability of funds and where the member is a valid and active member at the service date of the claim.
- 4.2. In line with legislative requirements, please ensure that when using your report writing billing code, you submit the ICD-10 diagnosis code(s). As per industry standards, the appropriate ICD-10 code(s) to use for this purpose would be those reflective of the actual condition(s) for which the form was completed. If funding for multiple conditions is applied for, then it would be appropriate to list all the relevant ICD-10 codes.
- 4.3. I understand that panel members from the relevant advisory panel (representatives from the relevant professional body) will review the information I provide by completing this form as well as the motivation I attach. This information will form part of the final recommendation

- and funding decision as communicated to the patient on the completion of this application process.
- 4.4. We will not consider cover for both a chiropractor and physiotherapist for the same condition.
- 4.5. We will not consider cover for both a psychologist and a social worker for the same condition.
- 4.6. As a healthcare funder, Discovery Health Medical Scheme funds treatments related to medical or clinical needs. When a medical scheme member applies for funding for additional allied, therapeutic and psychology benefits after they reached their annual family limit for the year, it is important to note that the additional benefit does not include therapies related to disorders of a scholastic nature (educational), including but not limited to school readiness testing. The additional benefit for allied, therapeutic and psychology services is not designed to fund any conditions of a non-clinical or non-medical nature. If the therapy is clinically indicated, we will require supporting information for current or retrospective review.
- 4.7. Certain assessments are not considered for funding through this application process, they are funded from day-to-day benefits subject to the annual family Allied, Therapeutic and Psychology Benefit limit.
- 4.8. Funding for additional healthcare services will only commence from when Discovery Health Medical Scheme receives a completed, signed form. Failure to complete all relevant information under each section of this form can result in the application being sent back for further information, in order to ensure that the review process can take place

information, in order to e	ensure that the review proces	s can take place		
5. Biokineticist section				
Please note: This section is the patient's name is exclude				e accepted. Due to confidentiality,
Membership number				
Patient age		Patient date of birth	D - M M -	Y Y Y Y
Healthcare professional name	e and surname			
BHF practice number				
Special interest				
Telephone (W)		Fax		
Email				
I acknowledge that I h	nave read and understood	the conditions for addition	nal benefits as menti	oned in section 4 on page 2.
Signature of healthcare profes	ssional		Date	D - M M - Y Y Y
5.1. Information about the pat	tient's condition			
5.1.1. Diagnosis details of cu	rrent diagnosis			
• •	Description	Date and nature of		Duration
ICD code(s)		incident / onset	< 12 weeks	> 12 weeks
	pine-related condition, please Professional Zone at www.di		levant biokinetic spinal	evaluation form which can be
Condition				
Cervical spine	Yes No			
Lumbar spine	Yes No			
5.2. Information about the pre	esent treatment required refer	ring to the above ICD-10 code	e	
Consultation or procedure code(s)	Length of sessions	(minutes) Number of to per week or	reatments required month	Number of total sessions required for the remainder of the current benef

diagnosis treatment

	_
ach description to show what phase the member is currently in.	'
.1. Number of sessions used	
ar Total amount of sessions (excluding additional benefit sessions that were approved)	Applied for additional
14	benefit Yes No
15	Yes No
16	
17	Yes No
	Yes No
18	Yes No
19	Yes No
20	Yes No
rt date of therapy in current year     D D - M M - Y Y Y Y   Y   Y   Y   Y   Y   Y   Y	
al number of sessions and frequency in current year:	
arnumber of sessions and frequency in current year.	
.2. Description of past treatment sessions to date, of above mentioned ICD 10 code (Please also indicate	te the procedure codes used)
.3. Motivation for treatment for above mentioned ICD 10 code (Include impact of treatment to date on fun	nctionality)
<u> </u>	

5.2.4. Goals for further treati	ment sessions			
5.2.5. Relevant patient histor primary diagnosis)	ry (Include previous diagnose	s, occupational and social fu	nctioning, previous treatment,	, hospitalisation, history of
6. Chiropractor section	1			
	s only to be completed by the	treating healthcare provider.	If not, the form won't be acce	pted. Due to
	name is excluded, but please			
Membership number				
Patient age		Patient date of birth	D - M M - Y	Y  Y
Healthcare professional nam	ie and surname			
BHF practice number				
Special interest				
Telephone (W)		Fax		
Email		I ax		
		4h   -     -		
i acknowledge that i	have read and understood	the conditions for addition	iai benefits as mentioned i	n section 4 on page 2.
Signature of healthcare professional			Date	D M M Y Y Y
6.1. Information about the pa	atient's condition			
6.1.1. Diagnosis details				
Please specify detailed	Description	Date and nature of		ation
ICD-10 code(s)		incident / onset	< 12 weeks	> 12 weeks

code(s)	Drocedure Length of sessions (minutes) Number of treatments required per week or month				Number of total sessions required for the remainder of the current benefit year to complete current diagnosis						
attach description to show wh	at phase the member is currently	in.									
.2.1. Number of sessions used											
fear Total amount of sessions	s (excluding additional benefit ses	sions that were approved)		plied for nefit	additional						
2015				Yes	No						
2016				Yes	No						
2017				Yes	No						
2018				Yes	No						
019				Yes	No						
020				Yes	No						
	sessions awarded in the previous	benefit year:		Yes	No						
Amount of additional funding solution of additional funding solution of the same of the sa	par DD - MM - YY	benefit year:    Y   Y		Yes	No						
Amount of additional funding solution of additional funding solution of the same of the sa	ear   D   D   -   M   M   -   Y   Y   Y   Y   Y   Y   Y   Y   Y	benefit year:		Yes	No						
Amount of additional funding sometimes  Original start date of therapy  Start date of therapy in current yeals  ast date of therapy in current yeals  Total number of sessions and free	ear DDD - MM - YY  ar DDD - MM - YY  quency in current year:	Y   Y   Y		Yes	No						
Amount of additional funding solution of additional funding solution of the same of the sa	ear   D   D   -   M   M   -   Y   Y   Y   Y   Y   Y   Y   Y   Y	Y   Y   Y		Yes	No						
Amount of additional funding sometimes  Driginal start date of therapy  Start date of therapy in current yeals  ast date of therapy in current yeals  Total number of sessions and free	ear DDD - MM - YY  ar DDD - MM - YY  quency in current year:	Y   Y   Y		Yes	No						
Original start date of therapy Start date of therapy in current ye ast date of therapy in current ye Total number of sessions and free	ear DDD - MM - YY  ar DDD - MM - YY  quency in current year:	Y   Y   Y		Yes	No						
Amount of additional funding sometimes of the property of the	ear DDD - MM - YY  ar DDD - MM - YY  quency in current year:	y y y y y cate the procedure codes used)		Yes	No						
Amount of additional funding start date of therapy start date of therapy in current yeast date.	ear DDD - MM - YY ar DDD - MM - YY quency in current year:	y y y y y cate the procedure codes used)		Yes	No						
Amount of additional funding sometimes of the property of the	ear DDD - MM - YY ar DDD - MM - YY quency in current year:	y y y y y cate the procedure codes used)		Yes	No						
Amount of additional funding sometimes of the property of the	ear DDD - MM - YY ar DDD - MM - YY quency in current year:	y y y y y cate the procedure codes used)		Yes	No						
Amount of additional funding and priginal start date of therapy  Start date of therapy in current years date of therapy in current years date of therapy in current years.  Fotal number of sessions and free 6.2.2. Description of past treatments	ear DDD - MM - YY ar DDD - MM - YY quency in current year:	y y y y y cate the procedure codes used)		Yes	No						

6.2.5. Relevant patient histo primary diagnosis)	ry (Include previous diagnose	es, occupational and social fu	unctioning, previous treatmen	t, hospitalisation, history of
6.2.5. Relevant patient histo primary diagnosis)	ry (Include previous diagnose	es, occupational and social fo	unctioning, previous treatmen	t, hospitalisation, history of
7. Occupational therap	ist section			
Please note: This section is	s only to be completed by the	treating healthcare provider	. If not, the form won't be acc	epted. Due to
confidentiality, the patient's	name is excluded, but please	make sure that you include	the patient's date of birth.	
Membership number				lv lv l
Patient age		Patient date of birth	D D - M M - Y Y	
Healthcare professional nam	ne and surname			
BHF practice number				
Special interest				
Telephone (W)	-	Fax	-	
Email				
I acknowledge that I	have read and understood	the conditions for addition	nal benefits as mentioned	in section 4 on page 2.
Signature of healthcare professional			Date	D M M Y Y Y
7.1. Information about the pa	atient's condition			
7.1.1. Diagnosis details				
Please specify detailed	Description	Date and nature of	Du	ration
ICD-10 code(s)		incident / onset	< 12 weeks	> 12 weeks

Consultation or procedure code(s)		Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year to complete current treatment						
7.2.1.	Number of sessions used									
		(excluding additional benefit ses	sions that were approved)		plied for nefit	additional				
2015					Yes	No				
2016					Yes	No				
2017					Yes	No				
2018					Yes	No				
2019					Yes	No				
2020					Yes	No				
2021					Yes	No				
Amoı	ınt of additional funding s	essions awarded in the previous	benefit year:							
Origin	al start date of therapy	D	Y   Y							
Start o	date of therapy in current yea	ar DDD-MMD-YY	Y Y							
_ast d	ate of therapy in current yea	ar DDD-MMD-Y	Y							
Total ı	number of sessions and freq	uency in current year:								
7.3. B	rief summary of occupationa	al therapy to date (Please also indica	ate the procedure codes used)							

7.4. Motivation for treatment (Include impact of treatment to date on functionality)
7.5. Detailed goals for further therapy
7.6. Brief history of patient's pre-morbid functioning and relevant patient history
<ul> <li>7.7. Motivation for treatment of adults – Please include additional motivation with this application including: Information about assistance required for participation in activities of daily living, functional transfers and upper limb function, cognitive and/or perceptual function, and pre-morbid work/school/university history. Please note: Standardised tests and scores should be indicated in reports when formal testing was included in the assessment. </li> <li>7.8. Motivation for treatment of children – Please include additional motivation with this application including: Information about impact on development, behaviour, school and social functioning, as well as relevant birth and background history. Please note: Standard scores should be indicated in reports when formal testing was included in the assessment. Please include additional assessment and progress reports with this application for paediatric cases. </li> </ul>
8. Physiotherapist section
Please note: This section is only to be completed by the treating healthcare provider. If not, the form won't be accepted. Due to
confidentiality, the patient's name is excluded, but please make sure that you include the patient's date of birth.
Membership number
Patient age  Patient date of birth DDD - MMM - YYYY
Healthcare professional name and surname

Telephone (W)  Email  I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.  Signature of healthcare professional  8.1. Information about the patient's condition  8.1.1. Diagnosis details  Please specify detailed (ICD-10 code(s)  Base and nature of inicident / onset of treatments required or week or month  8.2. Information about the treatment required  Consultation or procedure code(s)  Length of sessions (minutes)  Length of sessions (minutes)  Number of treatments required per week or month  Attach description to show what phase the member is currently in.  8.2.1. Number of sessions used  Year Total amount of sessions (excluding additional benefit sessions that were approved)  Applied for additional benefit  Yes No  2016  Yes No  2019  Yes No	BHF practice number																			
I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.    Date   Dat	Special interest																			
I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.  Signature of healthcare professional about the patient's condition  8.1.1. Diagnosis details  Please specify detailed [CD-10 code(s)]  Beacription   Date and nature of incident / onset   < 12 weeks   > 12 we	Telephone (W)		-						Fax			-								
Signature of healthcare professional B.1. Information about the petient's condition  8.1. Information about the petient's condition  8.1. Diagnosis details  Please specify detailed   Description   Date and nature of incident / onset   <12 weeks   >12 weeks    8.2. Information about the treatment required  Consultation or procedure code(s)   Length of sessions (minutes)   Number of treatments required per week or month   Number of total sessions required for the remainder of the current benefit year to complete current treatment treatment or code(s)   See   No    Attach description to show what phase the member is currently in.  8.2.1. Number of sessions used  Year Total amount of sessions (excluding additional benefit sessions that were approved)   Applied for additional benefit    Yes   No    Yes	Email				·															
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8.1. Information about the patient's condition 8.1.1. Diagnosis details Please specify detailed ICD-10 code(s)  Base and nature of incident / onset										_				In	ln	livi	IM.	ly	ly l	v Iv I
8.1. Information about the patient's condition 8.1.1. Diagnosis details  Please specify detailed ICD-10 code(s)  Please specify detailed ICD-10 code(s)  8.2. Information about the treatment required  Consultation or procedure code(s)  Length of sessions (minutes)  Number of treatments required per week or month  required for the remainder of the current benefit year  Attach description to show what phase the member is currently in.  8.2.1. Number of sessions used  Year Total amount of sessions (excluding additional benefit sessions that were approved)  Applied for additional benefit  Yes No  2016  Yes No  Y													D	ate		101	1.4.			
Please specify detailed ICD-10 code(s)    Date and nature of incident / onset	,																			
Please specify detailed   Description   Date and nature of incident / onset   < 12 weeks   > 12	8.1. Information about the pa	atient's o	conditic	n																
8.2. Information about the treatment required  Consultation or procedure code(s)  Length of sessions (minutes) Per week or month  Attach description to show what phase the member is currently in.  8.2.1. Number of sessions used  Year Total amount of sessions (excluding additional benefit sessions that were approved)  Applied for additional benefit Pers No  2016  Yes No  2017  2018  2019  2020  Amount of additional funding sessions awarded in the previous benefit year:	8.1.1. Diagnosis details																			
8.2. Information about the treatment required  Consultation or procedure code(s)  Length of sessions (minutes) Per week or month  Attach description to show what phase the member is currently in.  8.2.1. Number of sessions used  Year Total amount of sessions (excluding additional benefit sessions that were approved)  Applied for additional benefit 2015  Yes No  2016  Yes No  2016  Yes No  Yes No  2020  Yes No  Amount of additional funding sessions awarded in the previous benefit year:	Please specify detailed ICD-10 code(s)	Descri	ption							. 12	) wook			Du	_		a de a			
Consultation or procedure code(s)  Length of sessions (minutes)  Number of treatments required required for the remainder of the current benefit year to complete current treatment  Attach description to show what phase the member is currently in.  8.2.1. Number of sessions used  Year Total amount of sessions (excluding additional benefit sessions that were approved)  Applied for additional benefit  Yes No  2016  Yes No  2017  Yes No  2018  Yes No  2020  Yes No  Amount of additional funding sessions awarded in the previous benefit year:  Original start date of therapy										< 12	week	.5			>	IZ W	eks	•		
Consultation or procedure code(s)  Length of sessions (minutes)  Number of treatments required per week or month  Number of total sessions required for the remainder of the current benefit year to complete current treatment  Attach description to show what phase the member is currently in.  8.2.1. Number of sessions used  Year Total amount of sessions (excluding additional benefit sessions that were approved)  Applied for additional benefit  Yes No  2016  Yes No  2017  Yes No  2018  Yes No  2020  Yes No  Amount of additional funding sessions awarded in the previous benefit year:  Original start date of therapy						-														
Consultation or procedure code(s)  Length of sessions (minutes)  Number of treatments required per week or month  Number of total sessions required for the remainder of the current benefit year to complete current treatment  Attach description to show what phase the member is currently in.  8.2.1. Number of sessions used  Year Total amount of sessions (excluding additional benefit sessions that were approved)  Applied for additional benefit  Yes No  2016  Yes No  2017  Yes No  2018  Yes No  2020  Yes No  Amount of additional funding sessions awarded in the previous benefit year:  Original start date of therapy						-														
Consultation or procedure code(s)  Length of sessions (minutes)  Number of treatments required per week or month  Number of total sessions required for the remainder of the current benefit year to complete current treatment  Attach description to show what phase the member is currently in.  8.2.1. Number of sessions used  Year Total amount of sessions (excluding additional benefit sessions that were approved)  Applied for additional benefit  Yes No  2016  Yes No  2017  Yes No  2018  Yes No  2020  Yes No  Amount of additional funding sessions awarded in the previous benefit year:  Original start date of therapy						+														
Consultation or procedure code(s)  Length of sessions (minutes)  Number of treatments required per week or month  Number of total sessions required for the remainder of the current benefit year to complete current treatment  Attach description to show what phase the member is currently in.  8.2.1. Number of sessions used  Year Total amount of sessions (excluding additional benefit sessions that were approved)  Applied for additional benefit  Yes No  2016  Yes No  2017  Yes No  2018  Yes No  2020  Yes No  Amount of additional funding sessions awarded in the previous benefit year:  Original start date of therapy																				
per week or month required for the remainder of the current benefit year to complete current treatment  Attach description to show what phase the member is currently in.  8.2.1. Number of sessions used  Year Total amount of sessions (excluding additional benefit sessions that were approved)  Applied for additional benefit  Yes No  2016  Yes No  2017  Yes No  2018  Yes No  2020  Yes No  Amount of additional funding sessions awarded in the previous benefit year:  Original start date of therapy	8.2. Information about the tre	eatment	require	∍d																
the current benefit year to complete current treatment  Attach description to show what phase the member is currently in.  8.2.1. Number of sessions used  Year Total amount of sessions (excluding additional benefit sessions that were approved)  Applied for additional benefit  Yes No  2015  Yes No  2016  Yes No  2017  Yes No  2018  Yes No  2019  Yes No  2020  Yes No  Amount of additional funding sessions awarded in the previous benefit year:		е	Lengt	h of se	ssion	s (mi	nutes	)				requii	ed							or of
Attach description to show what phase the member is currently in.  8.2.1. Number of sessions used  Year Total amount of sessions (excluding additional benefit sessions that were approved)  Applied for additional benefit  Yes No  2015  Yes No  2017  Yes No  2018  Yes No  2019  Yes No  2020  Yes No  2020  Yes No  Amount of additional funding sessions awarded in the previous benefit year:	code(s)								per week o	1 111011				the c	urre	nt be	enef	it ye	ear	
8.2.1. Number of sessions used  Year Total amount of sessions (excluding additional benefit sessions that were approved)  Applied for additional benefit  Yes No  2016  Yes No  2017  Yes No  2018  Yes No  2019  Yes No  2020  Yes No  Yes No  2020  Yes No  Yes No  Amount of additional funding sessions awarded in the previous benefit year:  Original start date of therapy														to co	ompl	ete c	urre	ent t	reat	ment
8.2.1. Number of sessions used  Year Total amount of sessions (excluding additional benefit sessions that were approved)  Applied for additional benefit  Yes No  2016  Yes No  2017  Yes No  2018  Yes No  2019  Yes No  2020  Yes No  Yes No  2020  Yes No  Yes No  Amount of additional funding sessions awarded in the previous benefit year:  Original start date of therapy																				
8.2.1. Number of sessions used  Year Total amount of sessions (excluding additional benefit sessions that were approved)  Applied for additional benefit  Yes No  2016  Yes No  2017  Yes No  2018  Yes No  2019  Yes No  2020  Yes No  Yes No  2020  Yes No  Yes No  Amount of additional funding sessions awarded in the previous benefit year:  Original start date of therapy																				
8.2.1. Number of sessions used  Year Total amount of sessions (excluding additional benefit sessions that were approved)  Applied for additional benefit  Yes No  2016  Yes No  2017  Yes No  2018  Yes No  2019  Yes No  2020  Yes No  Yes No  2020  Yes No  Yes No  Amount of additional funding sessions awarded in the previous benefit year:  Original start date of therapy																				
8.2.1. Number of sessions used  Year Total amount of sessions (excluding additional benefit sessions that were approved)  Applied for additional benefit  Yes No  2016  Yes No  2017  Yes No  2018  Yes No  2019  Yes No  2020  Yes No  Yes No  2020  Yes No  Yes No  Amount of additional funding sessions awarded in the previous benefit year:  Original start date of therapy	Attach description to sho	w what	nhase	the m	embe	r is c	urren	tly in												
Year Total amount of sessions (excluding additional benefit sessions that were approved)  Applied for additional benefit  Yes No  2016  Yes No  2017  Yes No  2018  Yes No  2019  Yes No  2020  Yes No  2020  Yes No  Yes No  Amount of additional funding sessions awarded in the previous benefit year:  Original start date of therapy	Attach description to sho	w what	pilasc	the in	CIIIDC	1 13 0	uncin	y	•											
benefit  2015  Yes No  2016  Yes No  2017  Yes No  2018  Yes No  2019  Yes No  2020  Yes No  Amount of additional funding sessions awarded in the previous benefit year:  Original start date of therapy	8.2.1. Number of sessions u	ised																		
2015  2016  Yes No  Yes No  2017  Yes No  Yes No  2018  Yes No  Yes No  2019  Yes No	Year Total amount of ses	sions (e	excludi	ing add	dition	al bei	nefit s	sessi	ons that we	re app	roved	)					for	add	lition	nal
2017  Yes No  2018  Yes No  2019  Yes No  Yes No  2020  Yes No  Yes No  Yes No  2021  Yes No  Yes No  Yes No  Original start date of therapy	2015														DCI				No	
2017  Yes No  2018  Yes No  2019  Yes No  Yes No  2020  Yes No  Yes No  Yes No  2021  Yes No  Yes No  Yes No  Original start date of therapy	2016															Yes		_	Nο	
2018 2019 2020 2020 2021  Amount of additional funding sessions awarded in the previous benefit year:  Original start date of therapy  Pes No  Yes No  Yes No  Yes No	2017															1		_		
2019  Yes No  Yes No  Yes No  Yes No  Yes No  Original start date of therapy  Yes No  Yes No																res	L	_		
2020  2021  Yes No  Yes No  Amount of additional funding sessions awarded in the previous benefit year:  Original start date of therapy	2018															Yes			No	
2021  Yes No  Amount of additional funding sessions awarded in the previous benefit year:  Original start date of therapy	2019															Yes			No	
Amount of additional funding sessions awarded in the previous benefit year:  Original start date of therapy	2020															Yes			No	
Original start date of therapy	2021															Yes			No	
Original start date of therapy																				
Original start date of therapy	Amount of additional funding	g sessior	ns awa	rded in	the pi	reviou	ıs bene	efit ye	ear:											
Original start date of therapy					•			•												
Start date of therapy in current year	Original start date of therapy	/	D	D	- M	M	- Y	Υ	Y											
	Start date of therapy in curre	ent year	D	D	- M	M	- Y	Υ	Y											

Please note that this form expires on 31/03/2022. Up to date forms are always available on www.discovery.co.za under Medical Aid > Manage your health plan > Find important documents and certificates.

Last date of therapy in current year	
Total number of sessions and frequency in current year:	
8.2.2. Description of past treatment sessions to date (Please also indicate the procedure codes used)	
8.2.3. Motivation for treatment (Include outcome measures used and scores/impact of treatment to date on functionality)	
	_
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	_
8.2.4. Goals for further treatment sessions	
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	_
8.2.5. Relevant patient history (include previous diagnoses, occupational and social functioning, previous treatment, hospitalisation, birth history, milestones and history of primary diagnosis.)	
	_
	_
9. Psychologist section	
Please note: This section is only to be completed by the treating healthcare provider. If not, the form won't be accepted. Due to confidentialit the patient's name is excluded, but please make sure that you include the patient's date of birth.	/,
Membership number	
Patient age  Patient date of birth DDD - MM MD - YYYY	
Healthcare professional name and surname	

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9.1.3.	2. Current symptom presentations			
9.1.3.	3. Occupational and social functioning			
9.1.3.	4. Previous treatment			
9.1.3.	5. Hospitalisation			
9.1.3.	6. History of primary diagnosis (including a description of stressors for trauma and stressor-related dis	sorders)		
9.1.4.	Number of sessions used			
Year	Total amount of sessions (excluding additional benefit sessions that were approved)	App	olied for	r additional
2015			Yes	No
2016			Yes	No
2017			Yes	No
2018			Yes	No
2019			Yes	No
2020			Yes	No
2021			Yes	No
Amou	nt of additional funding sessions awarded in the previous benefit year:			
	. , , , , , , , , , , , , , , , , , , ,			
Origin	al start date of therapy   D   - M   M   - Y   Y   Y			

Please note that this form expires on 31/03/2022. Up to date forms are always available on www.discovery.co.za under Medical Aid > Manage your health plan > Find important documents and certificates.

Start date of therapy in current year	. D D . M M . Y	Y Y	
Last date of therapy in current year	D D - M M - Y Y	YY	
Total number of sessions and freque	ency in current year:		
9.2. Information about the treatment	: required		
Consultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year to complete current diagnosis
	·		
9.2.1. Indicate method(s) of treatme	ent and treatment to date		
		e years (Indicate impact of treatment	
functioning. For children, include	de information about impact on deve	elopment, behaviour, school and socia	al functioning.)
9.2.3. Motivation for additional treatr	ment		
9.2.4. If you are treating multiple me consideration	embers of the same family, please r	motivate and give clear reasons, as th	nis might pose an ethical

10. Social Worker (a	ddit	io	nal	me	ent	al I	hea	lthc	ar	e be	ene	fits	s)																					
Confirm that you are a	mer	nb	er c	of th	he [	Dis	cov	ery	He	alth	So	cia	ı w	orke	r in	Men	tal	He	alti	n N	etw	or/	k,	be	ore	e C	om	ple	tin	g ti	ne i	bel	ow	
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Membership number																																		
Patient age											F	Patio	ent	date	of bi	rth D		D	-	M	M		_	Υ	Υ		Υ	Υ						
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Special interest																																		
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Γ																																		
Signature of healthcare professional																					Da	te	D	D		-	M	M	_] -	. Y		Y	Υ	Υ
10.1. Information about the	he pa	atie	ent's	co	ndit	ion																												
10.1.1. Diagnosis details	-																																	
Please specify detaile	d	De	scri	ipti	on									ture	of										Dι	ıra	tio	n						
ICD-10 code(s)		_								inc	ide	ent /	/ on	set			<	12	we	ek	S					:	> 1	2 w	/ee	ks				
10.1.2. Multi-axial diagno	osis: I	Pl€	ease	e giv	ve a	DS	SM-	V dia	agn	osis	i																							
Current GAF and/or GAF		_		_					_					DSI	M-V												_							
Pre-treatment GAF and/		٩R	F																															
		_																									_							
Additional/supporting cor	mme	nts	abo	out	dia	gno	sis,	incl	udi	ng ir	npa	act c	on s	ocial	and	occı	ıpa	tior	nal/:	sch	ola	stic	c fu	ıncı	ion	ing	:							
10.1.3. Relevant patient I (Include previous di also indicate the pro	agno	se					al aı	nd so	ocia	al fur	nctio	onir	ng, p	orevio	ous t	reatn	nen	nt, h	osp	oita	lisa	itio	n, l	nist	ory	of	prir	mar	y d	iagr	าดร	is)	Plea	ase

1	Λ	1	1	Niu	mhar	of	sessions	nead

Year	Total amount of sessions (e	excluding additional benefit sess	ions that were approved)		olied for nefit	<sup>r</sup> additional
2015					Yes	No
2016					Yes	No
2017					Yes	No
2018					Yes	No
2019					Yes	No
2020					Yes	No
2021					Yes	No
Amou	nt of additional funding sessior	ns awarded in the previous benefit y	ear:			
Origin	al start date of therapy	D D - M M - Y Y	YY			
Start	date of therapy in current year	D D - M M - Y Y	Y Y			
Last c	ate of therapy in current year	D D - M M - Y Y	Y			
	number of sessions and freque					
	Information about the treatmen		Number of treatments required	Number o	of 40401 o	
code	ultation or procedure (s)	Length of sessions (minutes)	Number of treatments required per week or month	required the curre	for the	remainder of
10.2.1	. Indicate method(s) of treatm	ent and treatment to date				
(	Indicate impact of treatment to		e years nctioning. For children, include inforr	nation abo	ut impac	t on
(	development, behaviour, school	and social functioning.)				

10.2.3. Motivation for addition	onal trea	tment																				
11. Speech-language t	herani	st and	d au	diolo	nist	Sec	tion															
Please note: This section i									care provid	der. If	not,	the f	orm w	on't b	oe ac	ccei	pted.	Duc	e to			
confidentiality, the patient's	-		-	-			_		•													
Membership number						_																
Patient age							Pat	tient (	date of birth	n D	D	- N	M	-	Y	Y	Y	ľ				
Healthcare professional nar	ne and s	urnam	ie																			
BHF practice number																						
Special interest																						
Telephone (W)			-								Fax				-							
Email																						
Signature of healthcare professional														D	ate	D	D I	VI I	M Y	′ Y	Y	Y
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11.1. Information about the	-	-	-	31011011		юрс																
11.1.1. Diagnosis details																						
Please specify detailed	Descr	iption							ture of						D	ura	ation					
ICD-10 code(s)						inci	dent	/ on	set	-	< 12 ·	week	(S				> 12	we	eks			
11.2. Information about the																						
Consultation or procedur code(s)	re	Leng	th of	sessi	ons	(min	utes	)	Number o				requi	red	req the	uir cu	er of ed fo rren nplet	or th t be	ne re enefit	maiı t yea	nder ır	

# 11.2.1. Number of sessions used

Year	Total amount of sessions (excluding additional benefit sessions that were approved)	Ap <sub>l</sub> ber	olied for efit	additional
2015			Yes	No
2016			Yes	No
2017			Yes	No
2018			Yes	No
2019			Yes	No
2020			Yes	No
2021			Yes	No
Amou	nt of additional funding sessions awarded in the previous benefit year:			
Origin	al start date of therapy			
	late of therapy in current year			
Last d	ate of therapy in current year			
11.2.2	number of sessions and frequency in current year:  . Description of past treatment sessions to date (Please also indicate the procedure codes used)			
	. Motivation for treatment  Indicate impact of treatment to date on functionality)			
11 <i>2 4</i>	. Goals of further treatment sessions			

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(Ir	nclude previous diagnoses, occupational and social functioning, previous treatment, hospitalisation etc.
Fo	or children please include the child's birth history, milestones and history of primary diagnosis)
Ы	lease include additional assessment and progress reports to this application for paediatric cases

11.2.5. Relevant patient history