# Application for out-of-hospital treatment of a Prescribed Minimum Benefit condition 2021

**Who we are**

Discovery Health Medical Scheme, registration number 1125, is a not-for-profit organisation registered with the Council for Medical Schemes, and is the medical scheme that you are applying to become 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 from**

This form is to apply for out-of-hospital treatment of a Prescribed Minimum Benefit condition.

**What you must do**

- You need to complete section 1 of this form. 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 cannot be signed digitally. The main member and patient must sign and date any changes.
- Your healthcare professional must complete section 2.1, 2.2, 2.3, 2.4 and section 3 to apply for treatment for a Prescribed Minimum Benefit.
- Please include detailed documentation to support your application.
- Please email the signed form with any documentation to support this application to **PMB_APP_FORMS@discovery.co.za,** or get help on **www.discovery.co.za** under Medical Aid > Get Help > Submit a document and follow the guided steps through our Virtual Agent.
- You will receive a letter informing you of our decision and the process you should follow.

## 1. Patient details

Title ____ Initials ____

Surname ____

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

Preferred name ____

Gender ☐ F ☐ M Date of birth DD - MM - YYYY

ID or passport number ____ Country of issue ____

Membership number ____ Telephone (H) ____ - ____

Telephone (W) ____ - ____ Cellphone ____ - ____

Email ____

Relationship to main member ____

The outcome of this application will be communicated to you by email.

**Member's acceptance and permission**

I give permission for my healthcare provider to provide Discovery Health Medical Scheme and the administrator with my diagnosis and other relevant clinical information required to review my application. I agree to my information being used to develop registries. This means that you give permission for us to collect and record information about your condition and treatment. This data will be analysed, evaluated and used to measure clinical outcomes and make informed funding decisions.
I understand that:

1.1. Funding from the Prescribed Minimum Benefit (PMB) is subject to meeting clinical entry criteria requirements as determined by Discovery Health Medical Scheme.

1.2. The Prescribed Minimum Benefit (PMB) provides cover for disease-modifying therapy only, which means that not all medicines for a listed condition are automatically covered by Prescribed Minimum Benefits (PMBs).

1.3. By registering for Prescribed Minimum Benefits (PMBs), I agree that my condition may be subject to disease management interventions and periodic review and that this may include access to my medical records.

1.4. Funding for treatment from Prescribed Minimum Benefit (PMB) will only be effective from when Discovery Health Medical Scheme receives an application form that is completed in full.

1.5. An application form needs to be completed when applying for a new Prescribed Minimum Benefit (PMB) condition.

1.6. If you are approved on the benefit, you need to let us know when your treating doctor changes your treatment plan so that we can update your Prescribed Minimum Benefit (PMB) authorisation/s. You can do this by e-mailing the new prescription to us or asking your doctor or pharmacist to do this for you.

1.7. To make sure that we pay your claims from the correct benefit, we need the claims from your healthcare providers to be submitted with the relevant ICD-10 diagnosis code(s). Please ask your doctor to include your ICD-10 diagnosis code(s) on the claims they submit and on the form that they complete when they refer you to the pathologists and/or radiologists for tests. This will enable the pathologists and radiologists to include the relevant ICD-10 diagnosis code(s) on the claims they submit, ensuring that we pay your claims from the correct benefit.

**Consent for processing my personal information**

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. I understand that this information will be used for the purposes of applying for and assessing my funding request for Prescribed Minimum Benefits (PMBs). 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 and to relevant third parties, to administer the Prescribed Minimum Benefits (PMBs) as well as undertake managed care interventions related to the Prescribed Minimum Benefit (PMB) condition.

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

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

## 2. Application (healthcare professional to complete)

Date of diagnosis D D M M Y Y Y Y

### 2.1. Application for out-of-hospital treatment

| Condition | ICD-10 code | Consultation or procedure code | Description of treatment | Quantity per year |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

*The professional billing codes must be supplied for us to review the application.

Please attach any relevant supporting documents, for example pathology tests. If the application is for psychotherapy treatment for members younger than 13 years of age, the scheme will require the latest DSM V form including the GAF (Global assessment of Functioning) score.

### 2.2. Application for medicine

Current medicine required (please provide supportive clinical results or information, where necessary)

| Condition | ICD-10 code | Medicine name, strength and dosage | Number of months |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

### 2.3. Application for radiology

| Condition | ICD-10 code | Description of investigation | Quantity per year |
|---|---|---|---|
| | | | |
| | | | |

| | | | |
|---|---|---|---|
| | | | |
| | | | |

### 2.4. Application for pathology

| Condition | ICD-10 code | Description of investigation | Quantity per year |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## 3. Healthcare professional's details (healthcare professional to complete)

Name and surname

BHF practice number

Speciality

Telephone -

Email

The outcome of this application will be communicated to you by email.

**Notes to Healthcare Professional**

3.1. Please ensure that the relevant ICD-10 diagnosis code(s) are used when you submit your claims to the Scheme to ensure payment from the correct benefit.

3.2. Please include the ICD-10 diagnosis code(s) when referring your patient to the pathologists and/or radiologists. This will enable the pathologists and radiologists to include this information on their claims and allow us to comply with legislation by paying Prescribed Minimum Benefits (PMBs) claims correctly.

3.3. We will approve funding for generic medicine, where available, unless you have indicated otherwise.

3.4. Please submit all the requested supporting documents with this application to prevent delays in the review process.

3.5. Should you make changes to your patient's treatment plan, you need to let us know so that we can update their Prescribed Minimum Benefit (PMB) authorisation/s. You can do this by e-mailing the new prescription to us. If you or your patient do not let us know about changes to the treatment plan, we may not pay claims from the correct benefit.

Signature of healthcare professional

Date D D - M M - Y Y Y Y