

External Medical Items Extender Benefit application form 2021

Executive and Comprehensive Plans only
(incl. Classic Smart Comprehensive Plan)



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 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 details

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 form is to apply for the External Medical Items Extender Benefit. Please make sure you are using the most up to date form. Download the latest version of all forms from www.discovery.co.za > Medical Aid > Manage your plan > Find important documents and certificates.

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 treating doctor and cannot be signed digitally. The patient and or treating doctor must sign and date any changes.
- Member must complete and sign section 1 of the application form.
- Take the application form to your treating doctor to complete section 2, section 5, section 6 and section 7, and sign section 8.
- The application form must be sent together with an assessment report from an occupational therapist or physiotherapist and a quotation for the required external medical equipment.

Email the completed application form to clinicalhelp@discovery.co.za, or post it to Discovery Health Medical Scheme, PO Box 784262, Sandton 2146.

1. Patient information (to be completed by the member)

Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First name(s) (as per identity document)	<input type="text"/>		
Preferred name	<input type="text"/>	Gender	<input type="checkbox"/> M <input type="checkbox"/> F
		Date of birth	<input type="text"/>
ID Number	<input type="text"/>	Membership number	<input type="text"/>
Telephone (H)	<input type="text"/>	Telephone (W)	<input type="text"/>
Cellphone	<input type="text"/>		
Email	<input type="text"/>		
The outcome of this application will be sent to you by email.			
Signature of patient (if patient is a minor, main member or legal guardian to sign)	<input type="text"/>		Date <input type="text"/>

2. Health care professional's details

Full name and surname	<input type="text"/>
BHF practice number	<input type="text"/>
Speciality	<input type="text"/>
Telephone	<input type="text"/>
Email	<input type="text"/>

3. Notes to remember

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 the External Medical Items Extender Benefit.

I understand that:

- 3.1. Funding from the External Medical Items Extender Benefit is subject to meeting benefit entry requirements as determined by Discovery Health Medical Scheme.
- 3.2. The External Medical Items Extender Benefit only covers a defined list of external medical items as determined by Discovery Health Medical Scheme.
- 3.3. The External Medical Items Extender Benefit will only be applicable after the annual External Medical Items Benefit has been depleted and the funded medical equipment will be paid up to 100% Discovery Health Rate.
- 3.4. Funding from the External Medical Items Extender Benefit will only be effective from when Discovery Health Medical Scheme approved the application.
- 3.5. I will need to send an updated or new application form, if I need additional medical equipment in the same benefit year.
- 3.6. Consent for processing my personal information:
 - 3.6.1. 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.
 - 3.6.2. I understand that this information will be used for the purposes of applying for and assessing this application.
 - 3.6.3. I understand that by applying for the External Medical Items Extender Benefit my condition may be subject to benefit parameters and guidelines as determined by the relevant professional body, disease management interventions and periodic review for clinical evidence and cost-effectiveness which requires access to my medical records. I consent to Discovery Health Medical Scheme and the administrator accessing these records/information as long as the records/information are always kept confidential.
 - 3.6.4. 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 External Medical Items Extender Benefit.

4. Entry criteria for the External Medical Items Extender Benefit

- 4.1. If you are on an Executive or a Comprehensive Plan (including Classic Smart Comprehensive Plan) you may qualify for cover from the External Medical Items Extender Benefit if your annual External Medical Items (EMI) Benefit has been depleted.
- 4.2. All cases will be reviewed on individual merit and on case-by-case basis with severity of the condition and disability taken into consideration.
- 4.3. The decisions made will not set a precedent, determine future benefits or affect Discovery Health Medical Scheme in any way.
- 4.4. The defined list of external medical items applicable to this benefit should be obtained from a preferred supplier. Items not on the defined list will not be covered from the EMI Extender Benefit.
- 4.5. The external medical items frequency limits applicable to the EMI Benefit will also apply to the EMI Extender Benefit

List of qualifying conditions:

- Hemiplegia and paraplegia
- Quadriplegia (tetraplegia)
- Cerebral palsy
- Motor neuron Disease
- Parkinson's disease (and other movement disorders of the basal ganglia)
- Connective tissue disorder
- Severe injuries resulting in severe disabilities
- Spinal-muscular atrophy
- Multiple sclerosis (and other demyelinating CNS disorders)
- Muscular dystrophy

Product categories funded through the External Medical Items Extender Benefit

- Standard wheelchairs
- Lightweight wheelchairs
- Motorized wheelchairs
- Other specialised appliances such as activity chairs, customised wheelchairs, gait trainers etc.
- Wheelchair accessories e.g. cushions, arm rest, foot rests, side panels etc.
- Hoists
- Standing frames
- Scooters

Preferred suppliers:

- CE Mobility - 086 023 6624
- Chairmain Industries - 011 624 122/3/4
- Medop - 011 827 5893
- ShonaQuip - 021 797 8239

5. Condition (to be completed by healthcare professional)

ICD-10	Diagnosis description	Date when condition was first diagnosed							
		Y	Y	Y	Y	M	M	D	D
		Y	Y	Y	Y	M	M	D	D
		Y	Y	Y	Y	M	M	D	D
		Y	Y	Y	Y	M	M	D	D
		Y	Y	Y	Y	M	M	D	D

6. Additional clinical information (to be completed by healthcare professional)

7. External medical item required (to be completed by healthcare professional)

NAPPI or SAOPA code	Description

8. Notes to healthcare professional

- 8.1. The doctor's fee for completion of this form will be reimbursed on code 0199, 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 Scheme rules and availability of funds and where the member is a valid and active member at the service date of the claim.
- 8.2. In line with legislative requirements, please ensure that when using code 0199, 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 chronic condition(s) for which the form was completed. If funding for multiple chronic conditions were applied for, then it would be appropriate to list all the relevant ICD-10 codes.
- 8.3. Email the completed form to clinicalhelp@discovery.co.za.

Signature of healthcare professional Date - -

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