Request for additional cover for Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions registered on the Chronic Illness Benefit (CIB) 2021

Discovery Health Medical Scheme

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 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 to apply for additional cover for Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions registered on the Chronic Illness Benefit (CIB) and is only valid for 2021.

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.
- Email the completed and signed form to **CIB_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.
- 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 -

Email

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

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 Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) condition. Please complete the table below where the request is for further cover or for consultations or procedures not included in the treatment basket.

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

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 Prescribed Minimum Benefit (PMB) Chronic Disease List (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

BHF practice number

Speciality

Telephone -

Email

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

Signature of doctor

Date D D - M M - Y Y Y Y

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