

# Application for out-of-hospital treatment of a Prescribed Minimum Benefit condition 2026



## 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](http://www.discovery.co.za); PO Box 784262, Sandton, 2146; 1 Discovery Place, Sandton, 2196.

## Purpose of the form

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

## What you must do

- Fill in the form in black ink and print clearly or complete the form digitally. You can view the list of approved digital signature providers on [www.discovery.co.za](http://www.discovery.co.za), under Medical Aid > Find documents and certificates > Application forms.
- All relevant sections must be signed by the patient.
- 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.
- You can email the signed form with any supporting documentation to [PMB\\_APP\\_FORMS@discovery.co.za](mailto:PMB_APP_FORMS@discovery.co.za), or submit your documents on the [Discovery website](http://www.discovery.co.za) > Medical Aid > Get Help > Ask Discovery > Submit medical aid document and follow the guided steps through Ask Discovery.
- You will receive an email informing you of our decision and the process you should follow.
- If you would like to lodge a formal dispute to a declined decision and you have escalated your complaints through the relevant channels and are still unsatisfied with the outcome, or if you feel that the Scheme has not abided by its registered Rules or the provisions of the Medical Schemes Act, then you may lodge a dispute in terms of Scheme Rule 27. To do so, you may complete and submit a dispute form accessed from [www.discovery.co.za](http://www.discovery.co.za) > Medical aid > Find documents and certificates.

## 1. Patient details

Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First name(s)	<input type="text"/>		
ID or passport 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"/>		

## Nominate a primary care provider to manage your chronic condition(s)

There is overwhelming medical evidence that patients experience improved health outcomes when their primary care is coordinated through a single primary care GP. In line with this best practice, starting 1 January 2026, you and your dependants need to nominate a primary care GP for the effective management of your chronic conditions.

When you visit your nominated network GP for the management of your chronic condition, we'll cover the consultation at 100% of the Discovery Health Rate (DHR). If you see a GP who is not your nominated primary care GP, or your nominated GP is not a network GP, you will be responsible for any co-payments. You and your dependants can change your nomination three times every calendar year.

Nominate your GP or manage your existing nomination [here](#) or access the following path <https://www.discovery.co.za> > Medical aid > Nominate a primary care GP.

## Patient'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. Funding from the Prescribed Minimum Benefit (PMB) is subject to meeting benefit entry criteria as determined by Discovery Health Medical Scheme.
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).
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.
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.
5. An application form needs to be completed when applying for a new Prescribed Minimum Benefit (PMB) condition.
6. If I am approved on the benefit, I need to let you know when my treating doctor changes my treatment plan so that you can update my Prescribed Minimum Benefit (PMB) authorisation/s. I can do this by emailing the new prescription to you or asking my doctor or pharmacist to do this for me.
7. For my claims to be paid from the correct benefit, I need the claims from my healthcare professional to be submitted with the relevant ICD-10 diagnosis code(s). I will ask my doctor to include my ICD-10 diagnosis code(s) on the claims they submit and on the form that they complete when they refer me 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 you pay my 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 the Prescribed Minimum Benefits (PMB). 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 (PMB) as well as undertake managed care interventions related to the benefit. You can view and read our Privacy Statement on [www.discovery.co.za](http://www.discovery.co.za) > Medical aid > About Discovery Health Medical Scheme.

### Consent withdrawal for your Disease Management Benefits

Withdrawing consent for your general, personal, medical or clinical information to be accessed or shared with relevant third parties, means that you will no longer have access to funding from the applicable disease management benefits. Claims which would usually be funded from the disease management benefits will, once consent is withdrawn, be funded from other available benefits according to the rules of your plan. Should you wish to continue with the consent withdrawal process, then please call **0860 99 88 77**.

Signature of patient

(if patient is a minor, main member to sign)

Date



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

## 2. Application (healthcare professional to complete)

Please complete the table below where the request is for further cover or for consultations or procedures not included in the treatment basket.

Date of diagnosis

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

Condition	ICD-10 code	Consultation or procedure description and code	Quantity required	Motivation

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

Please attach any relevant supporting documents, for example pathology tests

### Applications for psychotherapy:

- You are required to complete the psychotherapy treatment application on HealthID to proceed.
- If the application is for psychotherapy treatment for members younger than 13 years of age, the Scheme will require the latest Diagnostic and Statistical Manual of Mental Disorders (DSM V) form including the Global Assessment of Functioning (GAF) score.

• Date of first psychotherapy session

Internet-based Cognitive Behavioural Therapy (iCBT) has been demonstrated to be a helpful adjunct to treatment for people with Major Depression\*. An iCBT course is included in the treatment basket for Major Depression for all members of participating schemes who are 18 years and older. iCBT will be funded as one (1) psychotherapy consultation from the member's Out-of-Hospital Treatment of a Prescribed Minimum Benefit, where PMB funding is approved. Qualifying members will be alerted that they have access to an iCBT course.

**Please indicate on the form below if you feel that information on iCBT should not be shared with this member.**

This member should not receive information on iCBT

If no preference is indicated, the member will be given more information on the iCBT course.

\*ICD-10 codes: F32.2; F32.3; F32.8; F32.9; F33.0; F33.1; F33.2; F33.3; F33.4; F33.8; F33.9, F34.0; F34.1; F53.1; F53.8; F53.9

**2.2 Application for medicine**

Please provide supportive clinical results or information, where necessary)

Condition	ICD-10 code	Medicine name, strength and dosage.	How long has the patient used this medicine?	
			Years	Months

**2.3 Application for radiology**

Condition	ICD-10 code	Procedure code	Procedure description	Quantity required

**2.4 Application for pathology**

Condition	ICD-10 code	Procedure code	Procedure description	Quantity required

**3. Motivation**

Please explain why you are applying for additional cover


#### 4. Referring healthcare professional's details (healthcare professional to complete)

Surname														
First name														
BHF practice number											Speciality			
Telephone														
Email														
Specialist BHF practice number														
Specialist first name and surname														

#### Notes to healthcare professional

- 4.1. 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.
- 4.2. We will need the details of the specialist (restricted to physicians, gastroenterologists and surgeons) who will be performing the gastroscopy procedure so that we apply the correct benefit.
- 4.3. We will approve funding for medicine as per a defined list of medicine applicable to this benefit.
- 4.4. Please submit all the requested supporting documents with this application to prevent delays in the review process.
- 4.5. Should you make changes to the information supplied, you need to let us know so that we can update the patient's authorisation/s. You can do this by emailing us. If we aren't informed about changes, we might not pay claims from the correct benefit.

Signature of healthcare professional

Date 

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