Contact us
Tel: 0800 BANKMED (0800 226 5633) • Private Bag X2, Rivonia, 2128 • www.bankmed.co.za

Oncology PMB application form

Request for additional cover from the Prescribed Minimum Benefits

Who we are
Bankmed (referred to as 'the Scheme'), registration number 1279, is a non-profit organisation, registered with the Council for Medical Schemes. Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07) which takes care of the administration of your membership for the Scheme.

Patient's name and surname

Membership number

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. Kindly complete this form if you wish to apply for additional cover for the diagnosis of, medicine for, or out-of-hospital management of a Prescribed Minimum Benefit (PMB) condition.
3. You (the member) must complete Section 1 of this form.
4. Your doctor must complete Section 2 and Section 3, and include detailed documents supporting your application.
5. Kindly send the completed and signed form, with any supporting documentation, to oncology@bankmed.co.za or fax to 011 539 5417.
6. Alternatively, post it to **Bankmed Medical Scheme, Oncology, Private Bag X2, Rivonia, 2128.**
7. You will receive a letter informing you of our decision and the process to follow for approved requests. You may also contact 0800 BANKMED (0800 266 5633) should you have any questions.

Please sign the form and ensure that all the relevant information required, as set out in the form is completed, including contact details for the provider and date of request.

1. About yourself (main applicant)

Title Initials Surname

ID number

Membership number Date of birth Y Y Y Y M M D D

Postal address

Code

Telephone (H) (W)

Cellphone Fax

E-mail address

Name of patient or dependant

May we communicate your information to you via: E-mail ☐ or Fax ☐

Has your treatment been approved on the Oncology Benefit? Yes ☐ No ☐

Should you have selected "Yes", your doctor is required to list the condition for which your treatment has been approved on the next page.

Patient's signature
(if patient is a minor, main member to sign)

Date Y Y Y Y M M D D

2. Information about treatment request (doctor to complete)

Diagnosis (incl. description) Date of Diagnosis: Y Y Y Y M M D D

Primary ICD 10 code: Secondary ICD code/s:

Diagnostic ☐ Ongoing Treatment/Monitoring ☐

2.1 Application for medical management which may include Pathology, Radiology and other condition related healthcare services)

* Medication requests: Initial requests will need to be accompanied by a valid script, thereafter a script only will be required for continuation

Date of service	Procedure code (NHRPL code)/ Treatment	Frequency/ Quantity	Claim related? Y/N (Please provide the date of service)

3. Doctor's details (doctor to complete)

Name and Surname

Practice number Speciality

Telephone Fax

E-mail address

Outcome of this application should be sent via: E-mail ☐ Fax ☐

Additional Notes:

1. You will be required to submit an Oncology PMB application form in instances where a member has exhausted his/her benefits from the Oncology Basket of Care.
2. Should the appeal have been approved, we will forward communication to you and the claim will be sent for re-processing.
3. Important to note: If the member still has sufficient benefits available, we will not provide you with an authorisation number as per our internal process.
4. You will also be requested to submit an Oncology PMB Application Form in instances where the item is not part of the Oncology Basket of Care available.

Please note, the submission of an Oncology PMB Application Form does not guarantee payment.

Doctor's signature Date Y Y Y Y M M D D