

Contact us

Tel: 0800 BANKMED (0800 226 5633) • PO Box 1242, Cape Town, 8000 • 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. About yourself (main applicant)

- 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, PO Box 1242, Cape Town, 8000.
- 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.

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Title	Initials				Surn	ame																								
ID number																														
Membership number																			Dat	e o	f bir	th	Υ	Y	Y	Y	Μ	Μ	D)
Postal address																														
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Telephone (H)																		(V	v) [] [
Cellphone																		Fa	ix] [
E-mail address																														
Name of patient or d	ependant																													
May we communicate	e your inform	mation	to yo	u via:	E-m	nail 🗌] 0	or F	ax																					
Has your treatment b	peen approve	ed on t	he On	colog	gy Ber	nefit?	Ye	s] N	o [
Should you have sele	ected "Yes", y	your do	octor i	s req	uired	to list	t the	e coi	nditi	on	for	whie	ch y	our	tre	eatn	nent	t ha	s be	een	app	orov	ved	on f	the	nex	t pa	nge.		
Patient's signature (if patient is a minor, main mem	nber to sign)																				Da	ate	Y	Y	Y	Y	M	Μ	D	D

2. Information abou	treatment request (doctor to complete)	
Diagnosis (incl. description)	Date of Diagnosis: Y Y Y M M	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

3. Doctor's details (doctor to complete)

Name and Surname																					
Practice number							S	pe	cial	ity											
Telephone		[]								Fa	x						
E-mail address																					

Outcome	of this	application	should	be sent vi	ia: E-ma	il 🗌	Fax
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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.



Bankmed Medical Scheme is a registered medical scheme with the Council for Medical Schemes (CMS). The CMS contact details are as follows: e-mail complaints@medicalschemes.com / Customer Care Centre: 0861 123 267 / website www.medicalschemes.com