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

Bariatric surgery application form

This application form is to apply for funding for bariatric surgery. It must be completed by a accredited surgeon from an accredited centre of excellence who will be performing the surgery. The member must complete sections 3, 4 and 6 of this form.

The turnaround time on receipt of a completed form is seven working days. We may require an additional three days should we need to forward the request to an external advisory panel before reaching a funding decision.

How to complete this form

1. Please use one letter per block, complete with black ink and print clearly
2. To avoid administration delays, please ensure this application is completed in full
3. Send the completed and signed form with the required clinical information and patient consent to us by e-mail at motivations@bankmed.co.za

1. Referring Healthcare Professional details (must be a surgeon, physician or endocrinologist)

Specialist name

Speciality

Specialist BHF number

Specialist HPCSA registration number

Telephone

Fax

E-mail address

Healthcare Professional's signature

Date (Y Y Y Y M M D D)

Name of facility where the procedure will be done

BHF number of the facility where the procedure will be done

2. Details of the surgeon performing the procedure (if it differs from section 1)

Surgeon name

Specialist BHF number

Specialist HPCSA registration number

Telephone

Fax

E-mail address

Healthcare Professional's Signature

Date (Y Y Y Y M M D D)

3. Principal Member information

Title

Initials

Surname

First name/s (as per identity document)

Date of birth (D D M M Y Y Y Y)

ID or passport number

Bankmed membership number

Bankmed Plan type

Postal address

Code

Telephone (H)

(W)

Cellphone

Fax

BANBSA001

4. Patient information

Title | Initials | Surname

First name | Sex M F | Date of birth Y Y Y Y M M D D

Telephone (H) | (W)

Cellphone | Fax

E-mail address

May we communicate your confidential information using the e-mail address provided? Yes No

May we communicate your confidential information using the fax address provided? Yes No

5. Clinical history

1. Current weight in kilograms (kg)	
2. Height in centimetres (cm)	
3. Waist circumference in centimetres (cm)	
4. Body Mass Index (BMI)	
5. Blood pressure Systolic/Diastolic	/
6. Body fat %	% (only for patients <150 kg)

Co-morbid illnesses

1. Diabetes mellitus	
2. Hypertension	
3. Dyslipidaemia	
4. Coronary artery disease	
5. Other (specify)	

Please note: Attach script for the treatment of the above co-morbidities

What is the proposed surgical procedure?

Type of bariatric surgery:	Roux-en-Y	
	Bilopancreatic diversion (BPD)	
	Gastric sleeve	
	Gastric band	

Please attach the following to this application form

1. Report from endocrinologist/physician
2. Report from bariatric surgeon
3. Report from clinical psychologist/psychiatrist
4. Copy of blood results (eg fasting glucose, lipogram, TSH, ALT/GGT, CRP etc)
5. Copy of gastroscopy report
6. Report from biokineticist/physiotherapist (where applicable)
7. Sleep apnoea studies (where applicable)
8. Dietician report
9. Supporting documentation from an anaesthetist verifying that the patient is medically fit to undergo an anaesthetic procedure

6. Consent to collection of data for outcomes measurement and registry requirements

I, (patient's name in full), hereby give Bankmed Medical Scheme and Discovery Health

(Pty) Ltd consent to the collection of all medical/clinical information pertaining to my application for _____ (name of medication/procedure/test) for the treatment of _____ (name of condition) as requested either from myself or my consulting Healthcare Professional _____ (Healthcare Professional's in full). In addition I specifically consent to Bankmed Medical Scheme and Discovery Health (Pty) Ltd having access to my clinical records at my Healthcare Professional's rooms for the purposes of conducting clinical audits. The information will be used for the purposes of measuring clinical outcomes and developing a registry that will allow Bankmed Medical Scheme to make informed funding decisions. The confidential nature of the information Bankmed Medical Scheme and Discovery Health (Pty) Ltd receives will be respected at all times. I understand that approval for funding for this treatment is conditional upon my cooperation with all aspects of this pre-assessment.

Patient's signature _____

If patient is a minor, Principal Member to sign

Date Y Y Y Y M M D D

Up to date forms are always available on www.bankmed.co.za