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

Application for out-of-hospital management of a Prescribed Minimum Benefit condition 2020

This is applicable to the Essential and Basic Plans

Please note that is form expires on 31/03/2021. Up-to-date forms are always available on www.bankmed.co.za

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.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly**.**
2. You (the member) must complete sections 1 of this form**.**
3. Your Healthcare Professional must complete section 2 and 3 and include detailed documents to support this application for treatment of a Prescribed Minimum Benefit condition**.**
4. Please e-mail completed and signed form with any supporting documents to **PMB_APP_FORMS@bankmed.co.za** or fax it to 011 539 1136**.**
5. You will receive a letter informing you of our decision and the process you should follow**.**

1. Important patientinformation (member to complete)

Title | Surname

First name/s

Sex M F | Identity number

Membership number | Telephone (H) -

(W) - | Cellphone -

E-mail address

Relationship to Principal Member

The outcome of this application can be communicated to me by email E-mail Fax

I give permission for my Healthcare Professional to provide Bankmed Medical Scheme or Discovery Health (Pty) Ltd with my diagnosis and other relevant clinical information required to review my application for Prescribed Minimum Benefits. I understand that:

1. Funding from the Prescribed Minimum Benefit is subject to clinical entry criteria as determined by Bankmed Medical Scheme or Discovery Health (Pty) Ltd.
2. Each case will be assessed on its own merit.
3. By registering for the Prescribed Minimum Benefits, I agree that my condition may be subject to disease management intervention and periodic review and that this may include access to my medical records.
4. Treatment approved as a Prescribed Minimum Benefit will only be effective from when Bankmed Medical Scheme or Discovery Health (Pty) Ltd receives an application form that is completed in full.
5. The covered Prescribed Minimum Benefit conditions and clinical entry criteria may change from time to time and I may be required to submit an updated or new application form, should Bankmed Medical Scheme or Discovery Health (Pty) Ltd request this.
6. Consent for processing my personal information
   - 6.1. I give the Scheme and Administrator consent to have access to and process all information (including general, personal, medical or clinical information) that is relevant to this application.
   - 6.2. I understand that this information will be used for the purposes of applying for and assessing my funding request for Prescribed Minimum Benefits.
   - 6.3. I consent to the Scheme and Administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical information) to my Healthcare Professional, to administer the Prescribed Minimum Benefits.

Patient (if patient is a minor, Principal Member to sign)

2. Application (Healthcare Professional to complete)

2.1. Application for out-of-hospital treatment*

Condition	Date of diagnosis	Treatment start date	Treatment end date	ICD-10 Code	Consultation or procedure code**	Motivation	Quantity

* Clearly specify what is required, for example consultations, pathology, radiology and/or procedure.
** The professional billing codes must be supplied for us to review the application.

Kindly attach any relevant supporting documentation, for example pathology tests.

When applying for mental health conditions for all children below the age of 13, please submit a DSM V form including the GAF (global assessment of functioning) score.

2.2. Application for medication

Current medication required (please provide supportive clinical results or information, where necessary)

Condition	ICD-10 code	Medication name, strength and dosage	Number of months

2.3. Application for radiology

Condition	ICD-10 code	Description of investigation	Quantity per year

2.4. Application for pathology

Condition	ICD-10 code	Description of investigation	Quantity per year

3. Healthcare Professional's details (Healthcare Professional to complete)

Name

Practice number

Fax -

Outcome of this application must be sent to me by E-mail Fax

Healthcare Professional's signature

Date D D - M M - Y Y Y Y