Bankmed
Yours in good health

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

Prescribed Minimum Benefits appeals form 2020

This is applicable to the Essential and Basic Plans

The latest version of this application form is available on www.bankmed.co.za. Alternatively, members and Healthcare Professionals may call 0800 BANKMED (0800 226 5633).

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.

About this form

This form should be completed when a member requires out-of-hospital treatment that falls outside of the basic level of care provided for in the Prescribed Minimum Benefits.

Kindly only complete this form if we have already reviewed a request for funding for your condition as a Prescribed Minimum Benefit. Otherwise please complete the Application for out-of-hospital management of a Prescribed Minimum Benefit condition form for review. .

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 and 2 of this form.
3. Your Healthcare Professional must complete section 3 and 4 and included detailed documents to support this application for treatment of a Prescribed Minimum Benefit.
4. Please e-mail this 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.
6. You may call us if you would like to lodge a formal dispute to a declined appeals decision.

1. Patient details (member to complete)

Name and surname

Date of birth D D M M Y Y Y Y Identity number

Membership number

Telephone (H) - (W) -

Cellphone - Fax -

E-mail address

Relationship to Principal Member

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

2. Notes to member

I give permission for my Healthcare Professional to provide Bankmed Medical Scheme and 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 clinic entry criteria as determined by Bankmed Medical Scheme and 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 interventions and periodic review and 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 clinic 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.

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Patient's signature

Date D D - M M - Y Y Y Y

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

I acknowledge that I have read and understood the conditions under “Notes to member” (section 2).

3. Application (Healthcare Professional to complete)

3.1. Application for out-of-hospital treatment*

Condition	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.

3.2. 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

3.3. Application for radiology

Condition	ICD-10 code	Description of investigation	Quantity per year

3.4. Application for pathology

Condition	ICD-10 code	Description of investigation	Quantity per year

BANPMB001

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

Name and surname

Practice number | Speciality

Telephone | Fax

E-mail address

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