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

HIV PMB application form

Request for additional cover from the Prescribed Minimum Benefits

Patient's name and surname

Membership number

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. To avoid administration delays, kindly ensure this application is completed in full.
2. Kindly complete this form should you wish to apply for additional cover for the diagnosis of, medication for, or out-of-hospital management of a Prescribed Minimum Benefit (PMB) condition.
3. You (the member) are required to complete section 1 and 2 of this form.
4. Your Healthcare Professional is required to complete section 3 and section 4, and include detailed documentation supporting your application.
5. Kindly send this completed and signed form with any supporting documentation by e-mail to **hiv@bankmed.co.za**, fax it to **011 539 3151** or post it to **Bankmed Medical Scheme, Private Bag X2, Rivonia 2128**. You may also contact our **Call Centre on 0800 BANKMED (0800 226 5633)** should you have any questions.
6. A dedicated case manager will contact both you and your treating Healthcare Professional to inform you about our funding decision and the process to follow should your application be approved.

1. Principal Member's details

Title | Initials | Surname

ID Number

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

Postal address

Code

Telephone (H) | (W)

Cellphone | Fax

E-mail

2. About the patient

Title | Initials | Surname

ID Number

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

Postal address

Code

Telephone (H) (W)

Cellphone Fax

E-mail

May we communicate your information to you by e-mail or fax

Relationship to Principal Member

Patient's signature Date of birth D D M M Y Y Y Y

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

3. Information about treatment request *(doctor to complete)*

3.1. Application for medical management

Out-of-hospital

Condition	RPL consultation or procedure code	RPL description	Number of consultations or procedures per year

3.2. Application for medicine

Medicine requested *(please provide details)*

Condition	Medicine name, strength and dosage	NAPPI code	Frequency

3.3. Application for radiology

Condition	Code	Description	Quantity

3.4. Application for pathology

Condition	Code	Description	Quantity

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

Name

BHF practice number

Fax

E-mail

Healthcare Professional's signature

Date D D M M Y Y Y Y