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

Prescribed Minimum Benefits appeals form 2021

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 the administrator with my diagnosis and other relevant clinical information required to review my application. I agree to my information being used to develop registries. This means that you give permission for us to collect and record information about your condition and treatment. This data will be analysed, evaluated and used to measure clinical outcomes and make informed funding decisions.

I understand that:

2.1. Funding from Prescribed Minimum Benefits is subject to meeting clinical entry criteria requirements as determined by Bankmed Medical Scheme and the administrator.
2.2. The Prescribed Minimum Benefit provides cover for disease-modifying therapy only, which means that not all medicines for a listed condition are automatically covered by Prescribed Minimum Benefits.

2.3. By registering for Prescribed Minimum Benefits, I agree that my condition may be subject to disease management interventions and periodic review and that this may include access to my medical records.

2.4. Funding for treatment from Prescribed Minimum Benefits will only be effective from when Bankmed Medical Scheme or the administrator receives an application form that is completed in full.

2.5. An application form needs to be completed when applying for a new PMB condition.

2.6. If you are approved on the benefit, you need to let us know when your treating doctor changes your treatment plan so that we can update your Prescribed Minimum Benefit authorisation/s. You can do this by e-mailing the new prescription to us or asking your doctor or pharmacist to do this for you.

2.7. To make sure that we pay your claims from the correct benefit, we need the claims from your Healthcare Professionals to be submitted with the relevant ICD-10 diagnosis code(s). Please ask your doctor to include your ICD-10 diagnosis code(s) on the claims they submit and on the form that they complete when they refer you to the pathologists and/or radiologists for tests. This will enable the pathologists and radiologists to include the relevant ICD-10 diagnosis code(s) on the claims they submit, ensuring that we pay your claims from the correct benefit.

Consent for processing my personal information

I give the Scheme and the administrator consent to have access to and process all information (including general, personal, medical or clinical information) that is relevant to this application. I understand that this information will be used for the purposes of applying for and assessing my funding request for Prescribed Minimum Benefits. I consent to the Scheme and the administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical information) to my Healthcare Professional and to relevant third parties, to administer the Prescribed Minimum Benefits as well as undertake managed care interventions related to the PMB condition.

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

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

Name and surname

BHF practice number

Speciality

Telephone

Fax

E-mail address

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

Notes to Healthcare Professional

4.1. Please ensure that the relevant ICD-10 diagnosis code(s) are used when you submit your claims to the Scheme to ensure payment from the correct benefit.

4.2. Please include the ICD-10 diagnosis code(s) when referring your patient to the pathologists and/or radiologists. This will enable the pathologists and radiologists to include this information on their claims and allow us to comply with legislation by paying Prescribed Minimum Benefits (PMB) claims correctly.

4.3. We will approve funding for generic medication, where available, unless you have indicated otherwise.

4.4. Please submit all the requested supporting documents with this application to prevent delays in the review process.

4.5. Should you make changes to your patient's treatment plan, you need to let us know so that we can update their PMB authorisation/s. You can do this by e-mailing the new prescription to us. If you or your patient do not let us know about changes to the treatment plan, we may not pay claims from the correct benefit.

Healthcare Professional's signature

Date D D M M Y Y Y Y