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

Request for additional cover for Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions 2022

Kindly complete this form if you are on a Bankmed Core Saver, Traditional, Comprehensive or Plus Plan and wish to request additional cover for your approved Chronic Disease List (CDL) condition.

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. Ensure you use one letter per block, complete in black ink and print clearly**.**
2. Kindly e-mail this completed and signed form to **chronicappeals@bankmed.co.za**
3. To avoid administrative delays, kindly ensure this form is completed in full by you and your Healthcare Professional**.**

1. About the patient (member to complete if patient is a minor)

Name and surname

ID / Passport number

Membership number

Telephone

Cellphone

E-mail address

The outcome of this application will be sent to you by e-mail.

I give consent to Bankmed Medical Scheme and Discovery Health (Pty) Ltd to use the above communication channel for all future communication.

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

2. Request for additional consultations and procedures (Healthcare Professional to complete)

Your patient has automatic access to an annual treatment basket containing a limited number of consultations and procedures when approved for a PMB CDL condition. Please complete the table below where the request is for further cover or for consultations or procedures not included in the treatment basket.

Condition	Consultation or procedure code	Number of consultations or procedures required per year	Supporting information for the request

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

Name and surname

Practice number

Specialty

Telephone

E-mail address

The outcome of this application will be sent to you by e-mail.

Healthcare Professional's signature

Date D D M M Y Y Y Y