

## Pre-assessment request

### 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.

**Should you sign this pre-assessment request, you confirm that the information provided is true and correct.**

Should you have any questions, kindly let us know. Once we have assessed your request, we will provide you with a pre-assessment letter.

### How to complete this application form

1. Please use one letter per block, complete with black ink and print clearly.
2. Alternatively, complete it electronically by typing in the fields below.
3. To avoid administration delays, please ensure this application is completed in full.
4. Please e-mail the completed form to [preassessments@bankmed.co.za](mailto:preassessments@bankmed.co.za)

### 1. Important details about pre-assessments

**A pre-assessment is conducted to enable you to compare the costs your Healthcare Professional will charge, against the costs your chosen Plan will cover. This does not replace the confirmation of benefits you still require from the Scheme.**

Please ensure you read and understand the following information regarding this pre-assessment form. Remember, this is a quote and does not guarantee payment.

**A pre-assessment is undertaken on request and you are required to request it prior to the procedure.**

We require pre-assessment at least three days prior to your procedure. Should the procedure be within the next seven days, contact us on **0800 BANKMED (0800 226 5633)** to inform us and we will do our best to ensure we complete the assessment prior to the procedure.

**We will provide a completed pre-assessment letter to you.**

Because the information in a pre-assessment is confidential, we will provide the completed assessment letter to you only. We will forward the letter to the preferred communication contact provided in the application. Should you not provide us with an e-mail address or should the details not belong to you, we will post it to the address we have on record for you.

**Contact us if you have any questions about this pre-assessment form**

If you need to check or query anything about this application, please contact us on **0800 226 5633**.

### 2. Principal member details

ID or passport number	<input type="text"/>
Name	<input type="text"/>
Surname	<input type="text"/>
Membership number	<input type="text"/>

### 3. Patient details

Title	<input type="text"/>	Initial(s)	<input type="text"/>
First name(s) (as per identity document)	<input type="text"/>		
Surname	<input type="text"/>		
How would you prefer to receive this letter?	E-mail <input type="checkbox"/>	Post <input type="checkbox"/>	
Will the procedure be conducted in- or out-of-hospital?	In <input type="checkbox"/>	Out <input type="checkbox"/>	
Was an authorisation number requested for the procedure from the Scheme?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Should the above response be yes, please provide the benefit reference number	<input type="text"/>		

#### 4. Healthcare Professional's details

Name

Billing practice number  Treating practice number

Contact number

Date of treatment 

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

#### 5. Medical details

Please note: you are required to provide a separate rand value for each procedure code - we cannot work with estimated or combined costs.

##### Healthcare Professional

Practice number	Procedure code	Rand value
<input type="text"/>	<input type="text"/>	R <input type="text"/>
<input type="text"/>	<input type="text"/>	R <input type="text"/>
<input type="text"/>	<input type="text"/>	R <input type="text"/>
<input type="text"/>	<input type="text"/>	R <input type="text"/>
<input type="text"/>	<input type="text"/>	R <input type="text"/>
<input type="text"/>	<input type="text"/>	R <input type="text"/>

##### Anaesthetics

Practice number	Procedure code	Time	Rand value
<input type="text"/>	<input type="text"/>	<input type="text"/>	R <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	R <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	R <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	R <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	R <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	R <input type="text"/>

Signed at (town or city)  on 

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Signature

(Principal Member to sign if patient is a minor)