

# Application for out-of-hospital treatment of a Prescribed Minimum Benefit condition 2023



## Who we are

Discovery Health Medical Scheme, registration number 1125, is a not-for-profit organisation registered with the Council for Medical Schemes, and is the medical scheme that you are a member of.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Discovery Health Medical Scheme and takes care of the administration of your membership.

## Contact us

Tel (members): 0860 99 88 77, Tel (health partners): 0860 44 55 66, [www.discovery.co.za](http://www.discovery.co.za), PO Box 784262, Sandton, 2146, 1 Discovery Place, Sandton, 2196.

## Purpose of the form

This form is to apply for out-of-hospital treatment of a Prescribed Minimum Benefit condition.

## What you must do

- You need to complete section 1 of this form. Fill in the form in black ink and print clearly, or complete the form digitally.
- All relevant sections must be signed by the patient.
- Your healthcare professional must complete section 2.1, 2.2, 2.3, 2.4 and section 3 to apply for treatment for a Prescribed Minimum Benefit.
- Please include detailed documentation to support your application.
- Please email the signed form with any documentation to support this application to [PMB\\_APP\\_FORMS@discovery.co.za](mailto:PMB_APP_FORMS@discovery.co.za), or submit your documents electronically on [www.discovery.co.za](http://www.discovery.co.za) under Medical Aid > Get Help > Submit a document and follow the guided steps through our Virtual Agent.
- You will receive an email informing you of our decision and the process you should follow.

## 1. Patient details

|                       |   |                  |                      |
|-----------------------|---|------------------|----------------------|
| Title                 | <input type="text"/>                                  | Initials         | <input type="text"/> |
| First name(s)         | <input type="text"/>                                  |                  |                      |
| Surname               | <input type="text"/>                                  |                  |                      |
| Preferred name        | <input type="text"/>                                  |                  |                      |
| Gender                | <input type="checkbox"/> M <input type="checkbox"/> F | Date of birth    | <input type="text"/> |
| ID or passport number | <input type="text"/>                                  | Country of issue | <input type="text"/> |
| Membership number     | <input type="text"/>                                  | Telephone (H)    | <input type="text"/> |
| Telephone (W)         | <input type="text"/>                                  | Cellphone        | <input type="text"/> |
| Email                 | <input type="text"/>                                  |                  |                      |

## Nominate a primary care provider to manage your chronic condition(s)

If you are approved for a Prescribed Minimum Benefit (PMB) condition, you must nominate a general practitioner (GP) in the Discovery Health GP network for your plan to be your primary care doctor for the management of your chronic conditions. You can nominate your primary care doctor in three simple steps.

- Log in to the Discovery app or [website](#)
- Navigate to nominate a primary care doctor
- Follow the prompts in the Care Portal and select your primary care doctor and their associated practice.

You can access your Care Portal on the Discovery app or website to update your nominated GP should you need to do so.

*(The Discovery app is brought to you by Discovery Health (Pty) Ltd; registration number 1997/013480/07, an authorised financial services provider and administrator of medical schemes.)*

## Patients acceptance and permission

I give permission for my healthcare provider to provide Discovery Health 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:

1. Funding from the Prescribed Minimum Benefit (PMB) is subject to meeting benefit entry criteria as determined by Discovery Health Medical Scheme.
2. The Prescribed Minimum Benefit (PMB) provides cover for disease-modifying therapy only, which means that not all medicines for a listed condition are automatically covered by Prescribed Minimum Benefits (PMBs).
3. By registering for Prescribed Minimum Benefits (PMBs), 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.
4. Funding for treatment from Prescribed Minimum Benefit (PMB) will only be effective from when Discovery Health Medical Scheme receives an application form that is completed in full.
5. An application form needs to be completed when applying for a new Prescribed Minimum Benefit (PMB) condition.
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 (PMB) authorisation/s. You can do this by emailing the new prescription to us or asking your doctor or pharmacist to do this for you.
7. To make sure that we pay your claims from the correct benefit, we need the claims from your healthcare professional 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 (PMBs). 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 provider and to relevant third parties, to administer the Prescribed Minimum Benefits (PMBs) as well as undertake managed care interventions related to the Prescribed Minimum Benefit (PMB) condition.

For the full Privacy Statement please refer to our website [www.discovery.co.za](http://www.discovery.co.za) > About us > Privacy.

Signature of patient

(if patient is a minor, main member to sign)

Date



**Please only sign if information is true, complete and correct.**

## 2. Application (healthcare professional to complete)

Please complete the table below where the request is for further cover or for consultations or procedures not included in the treatment basket.

Date of diagnosis

### 2.1 Application for out-of-hospital treatment

| Condition | ICD-10 code | Consultation or procedure code | Consultation or procedure description | Quantity required | Motivation |
|-----------|-------------|--------------------------------|---------------------------------------|-------------------|------------|
|           |             |                                |                                       |                   |            |
|           |             |                                |                                       |                   |            |
|           |             |                                |                                       |                   |            |
|           |             |                                |                                       |                   |            |
|           |             |                                |                                       |                   |            |
|           |             |                                |                                       |                   |            |
|           |             |                                |                                       |                   |            |

The professional billing codes must be supplied for us to review the application.

Please attach any relevant supporting documents, for example pathology tests.

Applications for psychotherapy:

- If the application is for psychotherapy treatment for members younger than 13 years of age, the scheme will require the latest Diagnostic and Statistical Manual of Mental Disorders (DSM V) form including the Global Assessment of Functioning (GAF) score

- Date of 1st psychotherapy session

## 2.2 Application for medicine

Current medicine required (please provide supportive clinical results or information, where necessary)

| Condition | ICD-10 code | Medicine name, strength and dosage | Consultation or procedure description | How long has the patient used this medicine? |        |
|-----------|-------------|------------------------------------|---------------------------------------|--|--------|
|           |             |                                    |                                       | Years  | Months |
|           |             |                                    |                                       |  |        |
|           |             |                                    |                                       |  |        |
|           |             |                                    |                                       |  |        |
|           |             |                                    |                                       |  |        |
|           |             |                                    |                                       |  |        |
|           |             |                                    |                                       |  |        |
|           |             |                                    |                                       |  |        |
|           |             |                                    |                                       |  |        |
|           |             |                                    |                                       |  |        |
|           |             |                                    |                                       |  |        |
|           |             |                                    |                                       |  |        |
|           |             |                                    |                                       |  |        |
|           |             |                                    |                                       |  |        |
|           |             |                                    |                                       |  |        |
|           |             |                                    |                                       |  |        |
|           |             |                                    |                                       |  |        |
|           |             |                                    |                                       |  |        |
|           |             |                                    |                                       |  |        |
|           |             |                                    |                                       |  |        |

## 2.3 Application for radiology

| Condition | ICD-10 code | Procedure code | Procedure description | Quantity required |
|-----------|-------------|----------------|-----------------------|-------------------|
|           |             |                |                       |                   |
|           |             |                |                       |                   |
|           |             |                |                       |                   |
|           |             |                |                       |                   |

## 2.4 Application for pathology

| Condition | ICD-10 code | Procedure code | Procedure description | Quantity required |
|-----------|-------------|----------------|-----------------------|-------------------|
|           |             |                |                       |                   |
|           |             |                |                       |                   |
|           |             |                |                       |                   |
|           |             |                |                       |                   |

## 3. Healthcare professional's details (healthcare professional to complete)

|                     |                      |                      |                      |            |                      |
|---------------------|----------------------|----------------------|----------------------|------------|----------------------|
| First name          | <input type="text"/> |                      |                      |            |                      |
| Surname             | <input type="text"/> |                      |                      |            |                      |
| BHF practice number | <input type="text"/> | <input type="text"/> | <input type="text"/> | Speciality | <input type="text"/> |
| Telephone           | <input type="text"/> | <input type="text"/> | <input type="text"/> | Email      | <input type="text"/> |

### Notes to Healthcare Professional

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.
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 pay claims correctly.
3. We will approve funding for medicine as per a defined list of medicine applicable to this benefit.
4. Please submit all the requested supporting documents with this application to prevent delays in the review process.
5. Should you make changes to your patient's treatment plan, you need to let us know so that we can update their authorisation/s. You can do this by emailing 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.

|                                      |                      |      |                      |                      |                      |                      |                      |                      |                      |
|--------------------------------------|----------------------|------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| Signature of healthcare professional | <input type="text"/> | Date | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
|--------------------------------------|----------------------|------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|

**Please only sign if information is true, complete and correct.**