

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

Please note that this form expires on the 31/03/2023. The latest version of the application form is available by logging in to www.mcmas.co.za. Alternatively, members can phone 0860 11 66 33 and healthcare professionals can phone 0860 44 55 66.

Who we are

The MultiChoice Medical Aid Scheme (referred to as 'the Scheme'), registration number 1241, 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). We take care of the administration of your membership for the Scheme.

About this form

This form should be completed when a member applies for out-of-hospital treatment of a Prescribed Minimum Benefit condition.

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 include detailed documents to support this application for treatment of a Prescribed Minimum Benefit condition.
4. Please email the completed and signed form with any supporting documents to PMB_APP_FORMS@discovery.co.za or fax it to **011 539 2780**.
5. You will receive a letter informing you of our decision and the process you should follow.

1. Patient information

Name and surname	<input type="text"/>																		
Date of birth	D	D	M	M	Y	Y	Y	Y	Identity number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Membership number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Telephone (H)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	(W)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Cellphone	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Fax	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email address	<input type="text"/>																		

The outcome of this application can be communicated to me via E-mail Fax

2. Notes to member

I give permission for my healthcare provider to provide the MultiChoice Medical Aid 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 benefit entry criteria as determined by the MultiChoice Medical Aid 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 Benefit will only be effective from when the MultiChoice Medical Aid 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 emailing 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 providers 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 provider 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

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

I acknowledge that I have read and understood the condition under "Notes to member" (section 2).

3. Application (healthcare professional to complete)

Date of diagnosis

3.1. Application for out-of-hospital treatment*

Condition	ICD-10 Code	Consultation or procedure code**	Consultation or procedure description	Quantity required

*Please 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.

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

3.2. Application for medicine

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

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

