CAMAF
MEDICAL SCHEME
IN A CLASS OF ITS OWN

APPLICATION FORM - OUT OF HOSPITAL MANAGEMENT OF PMB's

1. This form is only for registration of out of hospital prescribed minimum benefits (PMB) conditions. (Do not use this form for conditions listed under the CDL or Additional Chronic Conditions).
2. This form is only for registration of an initial or newly diagnosed PMB condition. For any changes to medication for an existing approval, please fax the prescription with the relevant ICD 10 codes to 011 707 8866.
3. One form must be completed per patient.
4. Once completed, please email, fax or post to:
   Email: pmbdtp@camaf.co.za
   Fax no: 011 707 8866
   Post: CAMAF, P.O. Box 2964, Randburg. 2125
5. Forms not completed in full will not be processed.
6. Section 1 of application form must be completed by the member.
7. Sections 2 and 3 must be completed by your doctor.
8. Approval of any PMB condition and medicine is subject to clinical entry criteria and drug utilisation reviews.
9. Reference Pricing applies to all PMB medicine.
10. CAMAF has appointed a Pharmacy Network for dispensing of PMB medicine. Should you choose not to purchase your PMB medicine from a Network Pharmacy a co-payment will apply. Please refer to CAMAF's website for a list of pharmacies in the network.
11. For any queries relating to this benefit please email us at pmbdtp@camaf.co.za
12. Attach copies of any reports to support the diagnosis of the PMB condition, where applicable.

1. PATIENT INFORMATION Please tick (✔) applicable box

Surname Initials

Full Name(s)

Membership No.:

RSA Identity No. Gender (M=Male; F=Female)

Date of Birth D D M M C C Y Y

Camaf Membership No.:

Telephone:

Home Code No. Cell No.

Work Code No. Fax Code No.

E-mail Address

We can contact you for feedback on your application via email ☐ or fax ☐

I understand that my application will not be processed if the information on this form is incomplete or the relevant diagnostic results are not provided to CAMAF. I give permission to my doctor to provide CAMAF with my diagnosis and other relevant clinical information to review my PMB application.

Principal Member Signature | Patient Signature (unless a minor) | Date

CAMAF Membership No.: | | | | | | | | |

2. PMB APPLICATION (DOCTOR TO COMPLETE)

2.1 PMB Condition Applied for:

ICD 10 Code	PMB Code	PMB Description	Date of Diagnosis	Ongoing / Acute Medical Management*

*Please confirm whether this condition is for acute or ongoing medical management.

2.2 Medicine Application

ICD 10 Code	Medicine name and Strength	Dosage	Quantity per month	Number of Months

2.3 Procedures Application

List all consultations, pathology, radiology, procedures and any other treatment required out of hospital

ICD 10 Code	Tarriff Code	Tarriff Description	Quantity	Start Date

3. DOCTOR DETAILS

Name

BHF Practice Number | | | | | | | |

Speciality _____

Telephone: Work | | | | | | | | | | |

Fax Number | | | | | | | | | | |

Doctor's Signature _____ Date D D M M C C Y Y

1. Please ensure all relevant reports and / or tests are included with this application form.
2. For completion of this application form use claim code 0199. Please remember to use the relevant diagnosis ICD 10 code with the claim.
3. This form only needs to be completed when applying for a new PMB condition. For any changes to the patient's medicine for approved conditions please call 0800 200 300 or please fax the prescription with the diagnostic ICD 10 code to 011 707 8622.