

# PMB PROGRAMME APPLICATION FORM

Please complete all the relevant sections of this form in BLOCK LETTERS.																		
MEMBERSHIP NUMBER												Opti	on					
SECTION A MEN	SECTION A MEMBERSHIP DETAILS																	
PRINCIPAL MEMBER DETAILS																		
PRINCIPAL MEMBER SURNAME																		
PRINCIPAL MEMBER FIRST NAM	MES																	
PRINCIPAL MEMBER ID NO.															GEN	DER	Μ	F
PATIENT DETAILS																		
PATIENT SURNAME																		
PATIENT FIRST NAME																		
PATIENT ID NO.															GEN	DER	Μ	F
DATE OF BIRTH	D	D	Μ	Μ	Y	Y	Y	Y					DEP	ENDA	NT CO	DDE		
POSTAL ADDRESS																		
POSTAL CODE																		
TEL. NUMBER (W)				-				-										
FACSIMILE NUMBER				-				-										
CELL																		
E-MAIL ADDRESS																		

١,

(patient's name and surname) the undersigned, declare that:

- a) I understand that all personal clinical information supplied to the PMB programme will be used to determine access to specific benefits for PMB conditions.
- b) The programme's Medical staff will review this information in order to make recommendations regarding the provision of these benefits. My/my dependant/s healthcare provider, however, retains responsibility for my/my dependant/s care, irrespective of the benefits so authorised.
- c) I/we therefore authorise any healthcare provider, hospital, clinic, laboratory and/or medical facility in possession of any medical information. regarding myself (the applicant) or any dependant (including new born baby), to provide the PMB programme with information that it may require.
- d) I warrant that the information in this application form is correct. I acknowledge that I will be responsible for any co-payments as per Scheme Rules or payment for any medication and/or investigations not authorised by the PMB team.
- e) I understand and agree that medical information relevant to my current state of health can be used for the purpose of scientific, epidemiological and/or financial analysis without disclosure of my identity.

f) I acknowledge that benefits authorised by the PMB programme are subject to Managed Care guidelines.

g) I am aware that more information on the PMBs can be obtained from the Scheme and the Council for Medical Schemes (CMS).

Date:	D	D	Μ	Μ	Υ	Y	Υ	Υ

SECTION B TRE	SECTION B TREATING HEALTHCARE PROVIDER DETAILS																	
PROVIDER SURNAME	М	I	L	L	Е	R								INITI	ALS	L	N	
PRACTICE NO.	0	7	6	θ	7	2	2	-										
POSTAL ADDRESS	1	3		S	С	0	t	t		S	t	r	е	е	t			
	W	А	V	Ε	R	L	Ε	Y		J	Η	В						
POSTAL CODE	2	0	9	0														
PHYSICAL ADDRESS	1	3		S	С	0	t	t		S	t	r	е	е	t			
	W	А	V	Е	R	L	Ε	Y		J	Η	В						
POSTAL CODE	2	0	9	0														
TELEPHONE NUMBER (W)	0	1	1	-	4	4	0	-	9	5	9	9						
CELL NUMBER												]						
E-MAIL ADDRESS	drl.	n.mi	lerps	sych	iatry	@gn	nail.o	com										
SECTION C TREATMENT (to be completed by the Healthcare Provider)																		
CLINICAL HISTORY	CLINICAL HISTORY																	
Please specify the condition for	Please specify the condition for which you are requesting access to PMB benefits.																	

Condition	ICD-10 Code	ls the patie on med	nt currently ication?	When was diagnosis first made?
		YES	NO	YEAR
		YES	NO	YEAR
		YES	NO	YEAR

## TREATMENT PLAN

	i	i
Procedure or consultation NHRPL tariff code	Procedure or consultation description	Number of procedures or consultations required per year
		consultation

ACUTE MEDICATION				
Condition	Drug Name	Drug Strength	Period Required	Quantity

Note: Chronic Medicine to be authorised via the Chronic Medicine Management process: Effective 1 June 2019: Tel: 086 000 2120 (member and provider) Email: preauth@mediscor.co.za

#### CLINICAL MOTIVATION

Please provide a brief outline of the reason for application.

## TREATMENT PLAN

Condition	Date of Test	Name of Test	Result

Date:	D	D	Μ	Μ	Υ	Υ	Y	Υ



Healthcare Provider's Signature

SECTION D

### MOTIVATION TO WAIVE NON-DSP RULES

A DSP is a healthcare provider or group of providers who have been selected by the Scheme to deliver the diagnosis, treatment and care in respect of PMB conditions to its members.

If you choose to use a healthcare provider other than the DSP for the treatment of a PMB condition, the Scheme may impose a co-payment or limit the rate at which claims are reimbursed.

Please select one of the reasons for the waiver request below:



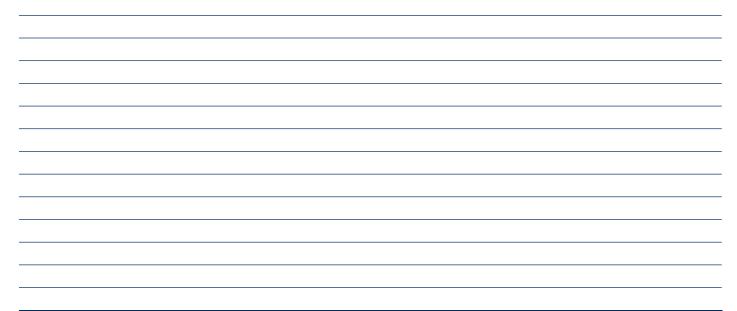
Service not available from DSP/could not be provided without unreasonable delay

Immediate (emergency) treatment required under circumstances where DSP could not be readily accessed

DSP not within reasonable proximity

#### Additional information in support of request:

Please note that application to waive the non-DSP override will not be considered unless sufficient proof is provided that treatment at the DSP could not be reasonably accessed.



## PLEASE FAX FORM TO +27 10 597 4706, EMAIL: pmb@medshield.co.za

Medshield Medical Scheme

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