Medimed
Managing your healthcare security

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EX-GRATIA APPLICATION FORM

SECTION A: IMPORTANT INFORMATION

1. Ex-gratia funding will only be considered by the Ex-gratia Committee subject to the Scheme's clinical protocols and guidelines.
2. This is discretionary funding for items and/or services not covered by the Scheme and/or benefits above the annual benefit limit.
3. An application must be completed per beneficiary applying for Ex-gratia.
4. The application will only be submitted to the Ex-gratia Committee for consideration if the form is completed in full including all supporting documents, motivations and/or quotations.
5. Please include any relevant specialists reports and test results that may assist with this application.
6. You will receive a letter confirming the Ex-gratia Committee's funding decision.
7. Please send completed forms by mail: PO Box 1672, Gqeberha, 6000 or email: ex-gratia@medimed.co.za or call (number) with any queries 086 177 7660.

SECTION B: BENEFICIARY DETAILS

Scheme | Option

Title | Initials | First Names | Surname

Medical Aid Number | Identity Number/ Passport Number | Date of Birth (Y Y Y Y M M D D)

Telephone Number (Home) | Cellphone Number

E-mail Address

Postal Address

Street Number / Street Name and Suburb

City and Province | Code

Monthly Income Category:

Note: *The committee may request proof of income at its discretion.*

Under R10 000 ☐ | R10 001 to R15 000 ☐ | R15 001 to R21 000 ☐ | R50 001 and above ☐

R21 001 to R30 000 ☐ | R30 001 to R40 000 ☐ | R40 001 to R50 000 ☐

Occupation
*(*optional information)*

SECTION C: CONDITION AND TREATMENT DETAILS *(to be completed by doctor)*

Description of condition(s)

Diagnoses - (ICD-10 codes)

Is/are the above condition(s) approved on the Chronic Medication Programme? Yes ☐ No ☐

If yes, Chronic Medication Authorisation Number(s) I H C | I H C

Medical Aid Number:

ADDITIONAL MEDICATION BENEFIT REQUESTED FOR THE FOLLOWING:			
Medication Name *	Strength	Dosage	Duration

Please complete the table below regarding the claim benefit category type(s) for this Ex-gratia application:

Benefit Type	**Item code and description**	**Cost**
GP/Specialist Consultations		
Dentistry *(Specialised/Basic)*		
Optometry		
Auxiliary *(treatment plan & progress report required)*		
Medical Appliance *(3 quotations to be supplied)*		
Specialised Radiology		
Non-Preferred Provider Pathology		
Oncology *(updated treatment plan required)*		
Internal Prosthesis *(3 quotations to be supplied)*		
Other (Specify)		

Medical History, Additional Clinical Information and Motivation for further funding
(applicable to both medication and other benefit types listed above):

** Kindly attach any additional supporting documentation pertinent to this request if not previously supplied.*

SECTION D: MEDICAL PRACTITIONER DETAILS

Surname | Initials

Practice Number | Speciality

Telephone Number (Home) | Cellphone Number

E-mail Address

Signature: | Date: Y Y Y Y M M D D

SECTION E: PATIENT DECLARATION

By signing below, I hereby give permission for, acknowledge and/or agree to the following:

- My (or my minor dependant's) doctor may provide clinical information regarding my/minor's condition to the Ex-gratia Committee;
- Any information concerning this application will remain confidential at all times. Medimed and the contracted Administrator will keep your personal information confidential and will adhere to the Protection of Personal Information Act, 2013 when processing your personal information. Your personal information will be processed for the purpose of the Medical Schemes Act 131 of 1998.
- MomentumTYB shall not accept responsibility for any act, errors or omissions, loss, damage or consequences of.

Print Name and Surname | Date: Y Y Y Y M M D D

Patient Signature:
(or member if patient is a minor) | Relationship (if guardian)