Medimed
Managing your healthcare security

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PRESCRIBED MINIMUM BENEFITS (PMB) APPLICATION

SECTION A: IMPORTANT INFORMATION

1. An application must be completed per beneficiary applying for funding.
2. You will receive communication regarding the outcome of this application.
3. The Scheme has a basket of diagnostic tests and consultations for each Chronic Disease List (CDL) Prescribed MinimumBenefit (PMB) condition.
4. Please attach the relevant claims to this form or alternatively complete the section for previously processed claims below.
5. Send completed forms to info@medimed.co.za or mail to PO Box 1672, Port Elizabeth, 6000

SECTION B: RULES APPLICABLE TO THE PRESCRIBED MINIMUM BENEFITS

1. The Scheme has selected the State as well as certain private service providers as the Designated Service Provider (DSP).
2. Should members voluntarily obtain a service from a provider other than the DSP, we will cover their claims as per the Scheme rules, i.e. subject to benefit limits and co-payments if applicable.
3. A claim will also be considered if a non-DSP has been used involuntarily.
4. If you require any further information or clarity regarding the funding and management of PMB's please contact Medimed at 041 395 4474 or visit the Medimed website.

SECTION C: PATIENT INFORMATION *(to be completed by member)*

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

Preferred way of communication *(please tick one option):* Tel (H) ☐ Cellphone ☐ Email ☐

SECTION D: DETAILS OF THE MEDICAL CONDITION *(to be completed by doctor)*

Please complete the table below regarding the PMB claim category type

Condition (ICD10 in brackets)	Tariff code	Quantity	Motivation

Attach relevant supporting documention, e.g. pathology results. If the application is for psychotherapy treatment of Major Depressive Disorder, the scheme will require the latest DSM V form including the GAF (Global Assessment of Functioning) score.

Doctors Details: Surname | Initials | Prac Number

Contact Number | Doctors Signature

Medical Aid Number:

SECTION E: CLAIM DETAIL

1. If we have processed the claim previously or if the claim has been sent directly to us, and you would now like it reimbursed from the Prescribed Minimum Benefits, please complete this section below.
2. You can obtain all the information about your claims from your claims statement.

Service Provider	Practice Number	Service Data	Treatment	Claim or Reference *(if previously paid)*
		Y Y M M D D		
		Y Y M M D D		
		Y Y M M D D		
		Y Y M M D D		
		Y Y M M D D		
		Y Y M M D D		
		Y Y M M D D		
		Y Y M M D D		
		Y Y M M D D		
		Y Y M M D D		

SECTION F: 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 Medimed Medical Scheme;
- 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.
- It may be a pre-condition to the approval of the Chronic Medication Benefit that I register and comply with the requirements of a Disease Management Programme and that non-compliance may lead to the withdrawal of this benefit;
- My (or my minor dependant's) doctor retains the responsibility for my (or my minor dependant's) condition, based on the understanding that I (or my minor dependant) also has a responsibility towards my (or my minor dependant's) own health concerns, irrespective of the outcome of this application.
- This funding authorisation is at all times subject to the Scheme rules even if a member's circumstances change after the authorisation is provided. This authorisation is not a guarantee of payment.
- This funding authorisation is based on the most appropriate clinical criteria in terms of the Scheme rules and protocols. All treatment decisions remain the responsibility of the of the beneficiary's health care provider irrespective of the funding decision made in terms of the Scheme rules, clinical criteria and protocols.
- The Adminstrator shall not accept responsibility for any act, errors or omissions, loss, damage or consequences of individual responses to the treatment authorised or not authorised for funding by the Scheme.

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)