

EX GRATIA APPLICATION FORM

A. IMPORTANT INFORMATION

An Ex-gratia benefit will only be considered by the Ex-gratia Committee subject to the Scheme's clinical protocols and guidelines.

This is a discretionary benefit for items and/or procedures not covered by the Scheme and/or benefits above the allocated annual benefit limit An application must be completed per member or beneficiary applying for Ex-gratia.

The application will only be forwarded to the Ex-gratia Committee for consideration if this form is completed in full and all the required reports, motivations and/or monetory quotes are attached.

All applications for Ex-gratia under R1 000 will not be considered.

You will receive a letter confirming the Ex-gratia Committee's decision.

Please send completed forms via fax: 041 395 4590, mail: PO Box 1672, Port Elizabeth, 6000 or email ex-gratia@medimed.co.za

B. APPLICANT DETA	ILS																											
Scheme														Op	otion													
Membership Number																												
Surname															First	t Nan	nes											
Title		Da	te of	Birth	n		Y	Y	Y	Y	Μ	Μ	D	D	ID N	lumb	er											
Telephone number (Hor	ne)														(Wo	ork)												
Fax number															Cell	ular												
Email address																												
Postal Address																												
																							Cod	е				
C. CONDITION AND	TRE	ATM	IENT	Γ DE	TAIL	_S F	OR I	EX -(GRA	TIA	CO	NSID	DERA	TIO	N (to	o be	com	plet	ed b	y do	octo	r)						
Description of condition	(s)																											<u> </u>
ICD-10 - Diagnosis Cod	e(s)							,						,						,								
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Is/are the above condition	on(s)) app	rove	d on	the F	harn	nacy	Ben	əfit N	lana	geme	ent C	hroni	c Me	dicat	ion F	Progra	amm	e?					Ye	s		No	
If yes, Chronic Medication	on A	uthor	risatio	on N	umbe	er(s)		I	Н	С										I	Н	С						
Medication Nam	ie *			A	DDI	FION.	AL N		CATI engti		BENI	EFIT	REQ	UES	TED		THE Dosa		LLO\	VING): ;				Dura	ation		
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Membership Number				<i>.</i>										

Please complete the table below regarding the claim benefit category type(s) for this Ex-gratia benefit application (other than medication):										
Benefit Type	Consultation/procedure/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.

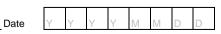
							-		-		-									
D. MEDICAL PRACT	THONER DE	IAILS																		
Surname																Init	ials			
Practice Number									Spec	ciality	[
Telephone Number]			Cellu	ılar										
Fax Number]														
Email Address																				
Signature										Date		[Y	Y	ΥY	Μ	Μ	D	D	
E. PATIENT DECLAR	RATION																			
By signing below, I he	reby give pern	nission for,	acknowled	lge and/or	agree	to the fo	llowing	g:												

My (or my minor dependant's) doctor may provide clinical information regarding my/minor's condition to the Ex-gratia Committee; ٠

• Any information concerning this application will remain confidential at all times;

. Medimed Medical Scheme 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.

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er if patient is a minor)	



Patient Sig (or membe



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