Registration Number 1506
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Medimed
Managing your healthcare security

EX GRATIA APPLICATION FORM

A. IMPORTANT INFORMATION

1 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
2 An application must be completed per member or beneficiary applying for Ex-gratia.
3 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.
4 All applications for Ex-gratia under R3 000 will not be considered.
5 You will receive a letter confirming the Ex-gratia Committee's decision.

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

B. APPLICANT DETAILS

Scheme | Option

Membership Number

Surname | First Names

Title | Date of Birth (Y Y Y Y M M D D) | ID Number

Telephone number (Home) | (Work)

Fax number | Cellular

Email address

Postal Address

Code

Monthly Income Category:

- Under R10 000
- R10 001 to R15 000
- R15 001 to R21 000
- R21 001 to R30 000
- R30 001 to R40 000
- R40 001 to R50000
- R50 001 and above

NOTE : THE COMMITTEE MAY AT ITS DISCRETION REQUIRE PROOF OF INCOME

Description of condition(s)

ICD-10 - Diagnosis Code(s)

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

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

ADDITIONAL MEDICATION BENEFIT REQUESTED FOR THE FOLLOWING:

Medication Name *	Strength	Dosage	Duration

Membership Number

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 PRACTITIONER DETAILS

Surname

Initials

Practice Number

Speciality

Telephone Number

Cellular

Fax Number

Email Address

Signature

Date Y Y Y Y M M D D

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 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.

Patient Signature
(or member if patient is a minor)

Date Y Y Y Y M M D D