ENGEN | Medical Benefit Fund

Administered by Discovery Health

Contact details
Tel: 0800 001 615 • PO Box 652509, Benmore, 2010 • www.engenmed.co.za

Application for out-of-hospital management of a Prescribed Minimum Benefit condition

Who we are

Engen Medical Benefit Fund (referred to as 'EMBF'), registration number 1572, is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the administrator') is a separate company, an authorised financial services provider and is responsible for the administration of your membership on behalf of the Fund.

About this form

This form should be completed when a member requires out-of-hospital management of a Prescribed Minimum Benefit Condition.

How to complete this form

Please ensure that all the relevant information required, as set out in the form is completed, including contact details for the provider and date of request.

1. Please use one letter per block, complete in black ink and print clearly.
2. You (the member) must complete sections 1 and 2 of this form.
3. Your healthcare professional must complete section 3.1, 3.2, 3.3, 3.4 for acute and/or ongoing treatment for a Prescribed Minimum Benefit conditions. Please include detailed documents supporting your application.
4. Please fax this completed and signed form with any detailed supporting documents to 011 539 2780 or email it to **PMB_APP_FORMS@engenmed.co.za**
5. Once we have processed your application, you will receive a letter informing you of our decision and the process you should follow for claims submission.

1. Important patient information

Title | Surname

First name/s

Gender (M / F) | Identity number | Membership number

Telephone (H) | Work

Cellphone | Fax

Email address

Relationship to principal member

The outcome of this application can be communicated to me by email Yes ☐ No ☐ or fax number Yes ☐ No ☐

2. Notes to members

I give permission for my healthcare professional to provide the Fund and Discovery Health (Pty) Ltd with my diagnosis and other relevant clinical information required to review my application for Prescribed Minimum Benefits. I consent to the Fund and Discovery Health (Pty) Ltd disclosing from time to time, information supplied to the Fund and Discovery Health (Pty) Ltd (including general or medical information that is relevant to my application) to my healthcare provider, to administer my benefits. I agree that the Fund may disclose this information at its discretion, but only as long as all the parties involved have agreed to always keep the information confidential. I understand that:

1. Funding from the Prescribed Minimum Benefit is subject to clinical entry criteria as determined by the Fund and Discovery Health (Pty) Ltd.
2. Each case will be assessed on its own merit.
3. By registering for the Prescribed Minimum Benefits, I agree that my condition may be subject to periodic review and that this may include access to my medical records.
4. No application for Prescribed Minimum Benefits will be considered for approval unless this application form is completed in full at the time of its submission.

2. Notes to members *(continued)*

5. The covered Prescribed Minimum Benefit conditions and clinical entry criteria may change from time to time and I may need to send an updated or new application form, if the Fund and Discovery Health (Pty) Ltd ask for this.

Consent for processing my personal information

I give the Scheme and the administrator consent to have access to and process all information (including general, personal, medical or clinical information) that is relevant to this application. I understand that this information will be used for the purposes of applying for and assessing my funding request for Prescribed Minimum Benefits. I consent to the Scheme and the administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical information) to my healthcare provider, to administer the Prescribed Minimum Benefits.

Patient's signature **(if patient is a minor, principal member to sign)**

Date Y Y Y Y M M D D

I acknowledge that I have read and understood the conditions under "Notes to member".

3. Application (healthcare professional to complete)

3.1 Application for acute and/or ongoing out-of-hospital medical management*

Condition	Date of diagnosis	Treatment start date	Treatment end date	ICD-10 code	Consultation or procedure code**	Motivation	Quantity

*Please clearly specify what is required, for example consultations, pathology, radiology and/or procedure.

**The professional billing codes must be supplied in order for us to review the application.

Please attach any relevant supporting documentation, for example pathology tests.

When applying for mental health conditions for all children below the age of 13, please submit a completed DSM IV or V form including the GAF (Global Assessment of Functioning) score.

3.2 Application for medicine

Current medicine required (please provide supportive clinical results or information)

Condition	ICD-10 code	Medicine name, strength and dosage	Number of months

3.3 Application for radiology

Condition	ICD-10 code	Description of investigation	Quantity per year

3.4 Application for pathology

Condition	ICD-10 code	Description of investigation	Quantity per year

4. Healthcare professional's details (healthcare professional to complete)

Name and surname

Practice number

Speciality

Telephone Fax

Email address

Outcome of this application must be sent to me via Email ☐ Fax ☐

Healthcare professional's signature

Date Y Y Y Y M M D D

5. Disclaimer

The healthcare professional's fee for completion of this form will be reimbursed on code 0199, on submission of a separate claim. Payment of the claim is from the day-to-day benefit, subject to Fund rules and availability of funds.

In line with legislative requirements, please ensure that when using code 0199, you submit the ICD-10 diagnosis code/s. As per industry standards, the appropriate ICD-10 code/s to use for this purpose would be those reflective of the actual Prescribed Minimum Benefit condition/s for which the form was completed. If multiple Prescribed Minimum Benefit conditions were applied for, then it would be appropriate to list all the relevant ICD-10 codes.