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 2020

**Who we are**

Engen Medical Benefit Fund (referred to as 'EMBF'), registration number 1572, is a not-for-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 treatment of a Prescribed Minimum Benefit condition. Please include detailed documents supporting your application.
4. Please email this completed and signed form with any detailed supporting documents to **PMB_APP_FORMS@engenmed.co.za** or fax it to **011 539 2780**
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 ____

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 disease management intervention and 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.
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.

Patient's signature | Date D D M M Y Y Y Y

**(if patient is a minor, principal member to sign)**

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

## 3. Application (Healthcare Professional to complete)

### 3.1. Application for out-of-hospital treatment

| Condition | Date of diagnosis | Treatment start date | Treatment end date | ICD-10 Code | Consultation or procedure code** | Motivation | Quantity |
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* Clearly specify what is required, for example consultations, pathology, radiology and/or procedure.
** The professional billing codes must be supplied for us to review the application.

Kindly 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 DSM 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, where necessary)

| Condition | ICD-10 code | Medicine name, strength and dosage | Number of months |
|---|---|---|---|
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### 3.3. Application for radiology

| Condition | ICD-10 code | Description of investigation | Quantity per year |
|---|---|---|---|
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### 3.4. Application for pathology

| Condition | ICD-10 code | Description of investigation | Quantity per year |
|---|---|---|---|
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EMBAOM001

Please note that this form expires on 31/03/2021. Up to date forms are available on www.engenmed.co.za.

## 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 E-mail [ ] Fax [ ]

Healthcare professional’s signature

Date D D M M Y Y Y Y