ENGEN Medical Benefit Fund

Administered by Discovery Health

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

Request for extra Prescribed Minimum Benefit (PMB) cover for HIV

This form is valid for 2024, the latest version of the application form is available on **www.engenmed.co.za**

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.

Please complete this form if you want to apply for extra cover for the diagnosis of, medicine for, or out-of-hospital management of a Prescribed Minimum Benefit (PMB) condition.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. Email the completed and signed form to **HIV@engenmed.co.za** or fax it to **011 539 3151**, or post it to Engen Medical Benefit Fund, **PO Box 652509, Benmore 2010**.
3. The doctor must complete section 2 and 3, and include detailed documents supporting your application.
4. Your doctor will receive a letter about our decision and the process to be followed for approved requests.

1. Patient details

Title | Initials

Surname

First name

ID Number | Date of birth (D D M M Y Y Y Y)

Postal address

Code

Telephone (H) | (W)

Cellphone

Personal email address

Relationship to principal member

May we communicate your confidential information to you at this email address — Yes | No

Has your condition been approved on the HIV Programme? — Yes | No

If **yes**, your doctor must list the condition for which you are approved on the next page.

Patient signature | Date (D D M M Y Y Y Y)

If minor, parent or guardian to sign

Patient's name and surname

Membership number

2. Application (doctor to complete)

2.1 Application for out-of-hospital medical management

Condition	Consultation or procedure code	Motivation and number of extra consultations or procedures

2.2 Application for medicine

Request for the current medicine (please provide details and relevant laboratory tests to show success of therapy, for example blood pressure reading or HBA1C)

Condition	Medication name, strength and dosage	Motivation and frequency

2.3 Previous medicine history

Medicine	Date medicine started	Length of therapy	Side effects experienced*	Lack of efficacy**

* Please provide details and severity
** Please provide details and attach laboratory test where appropriate

Patient's name and surname

Membership number

3. Doctor's details (doctor to complete)

Name of doctor

BHF practise number Speciality

Telephone

Email address

Doctor's signature Date D D M M Y Y Y Y

The outcome of this application must be communicated to me through my email address Yes No

or telephone number Yes No