HIV PMB application form

Request for additional cover from the Prescribed Minimum Benefits

Contact details

Tel: 0861 638 633 • PO Box 652509, Benmore 2010 • www.netcaremedicalscheme.co.za

This form is valid for 2022, the latest version of the application form is available on www.netcaremedicalscheme.co.za

Who we are

Netcare Medical Scheme, registration number 1584, is a non-profit organization, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as "the administrator") is a separate company and an authorised financial services provider (registration number1997/013480/07), which takes care of the administration of your membership of Netcare Medical Scheme.

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. Please complete this form if you wish to apply for additional cover for the diagnosis of, medicine for, or out-of-hospital management of a Prescribed Minimum Benefit (PMB) condition.
3. You (the member) must complete Section 1 of this form.
4. Your doctor must complete Section 2 and Section 3, and include detailed documents supporting your application.
5. Please email this completed and signed form with any support documentation to HIV@netcaremedicalscheme.co.za or fax to 0115393151. You can also contact our call centre on 0861 638 633 if you have any questions.
6. A dedicated case manager will call you and your treating doctor let you know about our funding decision and the process to follow if your application is approved.
7. To avoid administration delays, please ensure this application is completed in full.

1. Main member details

Title | Initials | Surname

ID Number

Membership number | Date of birth (D D M M Y Y Y Y)

Postal Address

Code

Telephone Home | Work

Cellphone | Fax

Email

2. About the patient

Title | Initials | Surname

ID Number

Membership number | Date of birth (D D M M Y Y Y Y)

Postal address

Code

Telephone Number (H) | (W)

Please note that this form expires on 31/03/2023. Up to date forms are available on www.netcaremedicalscheme.co.za.

NETHPA001

Cellphone Fax

Email address

May we communicate your information to you by Email or Fax

Relationship to main member

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

(if patient is a minor, main member to sign)

3. About the patient

May we communicate your information to you by email fax

Relationship to main member

Patient's signature Date D D M M Y Y Y Y
(if patient is a minor, main member to sign)

4. Information about treatment request (doctor to complete)

4.1. Application for medical management

Out-of-hospital

Condition	RPL consultation or procedure code	RPL description	Number of consultations or procedures per year

4.2. Application for medicine

Current medicine requested *(please provide details)*

Condition	Medicine name, strength and dosage	NAPPI code	Frequency

4.3. Application for radiology

Condition	code	Description	Quantity

4.4. Application for pathology

Condition	code	Description	Quantity

5. Doctor's details (doctor to complete)

Name

Practice number

Fax

Doctor's signature

Date Y Y Y Y M M D D