MEDICAL AID SCHEME

Administered by Discovery Health

Contact details
Tel: 0860 123 077 • PO Box 652509, Benmore 2010 • www.tfgmedicalaidscheme.co.za

Application for out-of-hospital management of a Prescribed Minimum Benefit condition 2019

The latest version of the application form is available on www.tfgmedicalaidscheme.co.za. Alternatively members can phone 0860 123 077 and health professionals can phone 0860 44 55 66.

Who we are

TFG Medical Aid Scheme (referred to as 'the Scheme'), registration number 1578, is a non-profit organisation, 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 number 1997/013480/07). We take care of the administration of your membership for the Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. You (the member) must complete sections 1 of this form.
3. Your Healthcare professional must complete section 2 and 3 and included detailed documents to support this application for acute and/or ongoing treatment for a Prescribed Minimum Benefit.
4. Please fax this completed and signed form with any supporting documents to 011 539 2780 or email it to **PMB_APP_FORMS@discovery.co.za**
5. 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

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

Telephone (H) | (W)

Cellphone | Fax

Email address

Relationship to main member

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

I give permission for my Healthcare professional to provide TFG Medical Aid Scheme with my diagnosis and other relevant clinical information required to review my application for Prescribed Minimum Benefits. I consent to TFG Medical Scheme and Discovery Health (Pty) Ltd disclosing from time to time, information supplied to TFG Medical Scheme 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 TFG Medical Scheme 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 TFG Medical Aid Scheme.
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. Treatment approved as a Prescribed Minimum Benefit will only be effective from when TFG Medical Aid Scheme receives an application form that is completed in full.
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 TFG Medical Aid Scheme asks for this.

Main member's signature

Patient (unless a minor)

2. Application (Healthcare professional to complete)

Date of diagnosis Y Y Y Y M M D D Treatment start date Y Y Y Y M M D D Treatment end date Y Y Y Y M M D D

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

Condition	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 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 DSM IV or V form including the GAF (global assessment of functioning) score.

2.2 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

2.3 Application for radiology

Condition	ICD-10 code	Description of investigation	Quantity per year

2.4 Application for pathology

Condition	ICD-10 code	Description of investigation	Quantity per year

3. Healthcare professional's details

Name

Practice number Fax

Email address

Healthcare professional's signature

Date Y Y Y Y M M D D

4. 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 subject to TFG Medical Aid Scheme 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.