Contact details
Tel: 0860 123 007 • PO Box 652509, Benmore 2010 • www.tfgmedicalaidscheme.co.za

Appeal for out-of-hospital treatment over and above that provided by the Prescribed Minimum Benefits 2020

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

The latest version of the application form is available on www.tfgmedicalaidscheme.co.za. Alternatively, members can call 0860 123 077 and healthcare professionals can call 0860 44 55 66 for us to send the latest form.

About this form

This form should be completed when a member needs out-of-hospital treatment that falls outside of the basic level of care provided for in the Prescribed Minimum Benefits.

Please only complete this form if we have already reviewed and declined a request for funding for your condition as a Prescribed Minimum Benefit. Otherwise please refer to the Application for out-of-hospital management of a Prescribed Minimum Benefit condition.

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 and 2 of this form.
3. Your Healthcare professional must complete section 3 and 4 and include detailed documents to support this application for treatment for your Prescribed Minimum Benefit condition.
4. Please email this completed and signed form with any supporting documents to PMB_APP_FORMS@discovery.co.za or fax it to 011 539 2780
5. You will receive a letter informing you of our decision and the process you should follow..
6. You may call us if you would like to lodge a formal dispute to a declined appeals decision.

1. Patient details

Name and surname

Date of birth D D M M Y Y Y Y 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 ☐ Fax ☐

2. Notes to member

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 requirements as determined by TFG Medical Aid Scheme 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 interventions and periodic review and 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 or and Discovery Health (Pty) receives an application form that is completed in full.
5. The covered Prescribed Minimum Benefit conditions and clinical entry requirements may change from time to time and I may need to send an updated or new application form if TFG Medical Aid Scheme or Discovery Health (Pty) Ltd asks for this.

Patient’s signature [ ] Date D D M M Y Y Y Y

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

I acknowledge that I have read and understood the conditions under “Notes to member” (section 2).

3. Application (Healthcare professional to complete)

3.1. Application for out-of-hospital treatment*

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 documents, 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

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

Name and surname

Practice number

Speciality

Telephone | Fax

Email address

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

Healthcare professional's signature

Date D D M M Y Y Y Y