



Contact details

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

Application for out-of-hospital management of a Prescribed Minimum Benefit condition 2020

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 treatment for a 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.

1. Important patient information

Title	<input type="text"/>	Surname	<input type="text"/>
First name/s	<input type="text"/>		Sex <input type="checkbox"/> M <input type="checkbox"/> F
ID Number	<input type="text"/>	Membership number	<input type="text"/>
Telephone (H)	<input type="text"/>	(W)	<input type="text"/>
Cellphone	<input type="text"/>	Fax	<input type="text"/>
Email address	<input type="text"/>		
Relationship to main member	<input type="text"/>		

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

I give permission for my Healthcare professional to provide TFG Medical Aid Scheme 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 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 and Discovery Health (Pty) Ltd 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 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. Treatment approved as a Prescribed Minimum Benefit will only be effective from when TFG Medical Aid Scheme or Discovery Health (Pty) Ltd 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 or Discovery Health (Pty) Ltd or Discovery Health (Pty) Ltd asks for this.
6. Consent for processing my personal information
 - 6.1. I give the Scheme and the administrator consent to have access to and process all information (including general, personal, medical or clinical information) that is relevant to this application.
 - 6.2. I understand that this information will be used for the purposes of applying for and assessing my funding request for Prescribed Minimum Benefits.
 - 6.3. I consent to the Scheme and Administrator disclosing, from time to time, information supplied to them (including general, personal,

medical or clinical information) to my healthcare provider, to administer the Prescribed Minimum Benefits.

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

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2. Application (healthcare professional to complete)

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

2.1 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 in order 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 completed DSM 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, where necessary)

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 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