TFG MEDICAL AID SCHEME

Administered by Discovery Health

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

HIV PMB application form

This form is valid for 2021, the latest version of the application form is available on www.tfgmedicalaidscheme.co.za

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.

Patient name and surname

Membership number

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. To avoid administration delays, please ensure this application is completed in full and signed.
3. 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.
4. You (the member) must complete Section 1 and Section 2 of this form.
5. Your doctor must complete Section 3 and Section 4, and include detailed documents supporting your application.
6. Please email this completed and signed form with any support documentation to HIV_Diseasemanagement@discovery.co.za or fax to 011 539 3151 or post it to TFG Medical Aid Scheme, PO Box 536, Rivonia, 2128.
7. 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.
8. You can also contact our call centre on 0860 123 077 if you have any questions.

1. Main member's details

Title | Initials | Surname

First name/s (as per identity book)

Membership number

Postal Address

Code

Telephone Number (H) | (W)

Cellphone | Fax

Email address

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)

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. Information about treatment request *(Doctors to complete)*

3.1. Application for medical management

Out-of-hospital

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

3.2. Application for medication

Current medication requested

Condition	Medication name, strength and dosage	NAPPI code	Frequency

3.3. Application for radiology

Condition	Code	Description	Quantity

3.4. Application for pathology

Condition	Code	Description	Quantity

4. Doctor's details (doctor to complete)

Name of doctor

Practice number

Fax

Doctor's signature

Date D D M M Y Y Y Y