Request for extra Prescribed Minimum Benefit (PMB) cover related to HIV

Who we are

Discovery Health Medical Scheme, registration number 1125, is a not-for-profit organisation registered with the Council for Medical Schemes, and is the medical scheme that you are a member of.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Discovery Health Medical Scheme and takes care of the administration of your membership.

Contact us

Tel (members): **0860 99 88 77**, Tel (health partners): **0860 44 55 66**, **www.discovery.co.za**, PO Box 784262, Sandton, 2146, 1 Discovery Place, Sandton, 2196.

Purpose of the form

Please complete this form if you want to apply for extra cover for the diagnosis of, medicine for, or out-of-hospital management of a Prescribed Minimum Benefit (PMB) condition related to HIV.

What you must do

- Fill in the form in black ink and print clearly, or complete the form digitally. You can view the list of approved digital signature providers on **www.discovery.co.za**, under Medical Aid > Find documents and certificates > Application forms.
- All relevant sections must be signed by the patient and/or doctor. The patient and/or doctor must sign and date any changes.
- Email the completed and signed form to **HIV_Diseasemanagement@discovery.co.za.**
- The doctor must complete section 2 and 3, and include detailed documents supporting your application.
- Your doctor will receive a letter about our decision and the process to be followed for approved requests**.**
- From 1 January 2025 you and your dependants on all health plans except the Executive Plan, need to nominate a primary care GP for the management of your chronic conditions. When you visit your nominated network GP for the management of your chronic condition, the Scheme will cover the consultation at 100% of the Discovery Health Rate (DHR). If you see a GP who is not your nominated primary care GP, or your nominated GP is not a network GP, you will experience a co-payment. Nominate your GP or manage your existing nomination on **www.discovery.co.za** > Medical aid > Nominate a primary care GP.

1. Patient details

When do you want your cover to start? D D M M Y Y Y Y

Title Initials

First name(s)

Surname

Gender M F Date of birth D D M M Y Y Y Y

Membership number

ID or passport number

Telephone (H) Telephone (W)

Cellphone

Email

Postal address(post collected from post box, suite or private bag)

PO Box Private bag Box number

Suite Postnet suite Number

Suburb Post code

Relationship to main member

Has your condition been approved on the HIV Care Programme? Yes No

If **yes,** your doctor must list the condition for which you are approved where it is requested on this application form.

Please note: confidential information related to this application will be communicated to you by email, to the email address provided above.

Signature of patient (If patient is a minor, parent/guardian to sign) | | Date D D M M Y Y Y Y

Please only sign if information is true, correct and complete.

2. Application (doctor to complete)

2.1. Application for out-of-hospital medical management

Condition	Consultation or procedure code	Motivation and number of extra consultations or procedures

2.2. Application for medicine

Request for the current medicine (please provide details and relevant laboratory tests to show indication for therapy)

Condition	Medicine name	Motivation and number of extra medicines and dosages

2.3. Previous medicine history

Medicine	Date medicine started	Length of therapy	Side effects experienced*	Lack of efficacy**

** Please provide details and severity.*

*** Please provide details and attach laboratory test where appropriate.*

Discovery Health Medical Scheme, registration number 1125, is regulated by the Council for Medical Schemes and administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider.

3. Doctor's details (doctor to complete)

First name(s)

Surname

BHF practice number

Billing practice number

Group practice number

Speciality

Telephone

Email (preferred email to receive patient progress reports)

The outcome of this application must be communicated to me by Email ☐ Telephone ☐

Signature of doctor

Date D D M M Y Y Y Y

Please only sign if information, is true, complete and correct.