MEDSHIELD
medical scheme

PMB PROGRAMME APPLICATION FORM

Email: PMBApplications@medshield.co.za

Please complete in black ink. Print clearly using capital letters. Only one character per block. Leave one block between words.
Mark with an X where necessary. All sections must be completed.

Membership Number:

SECTION A MEMBERSHIP DETAILS

Principal Member Surname:

Principal Member First Names:

Principal Member ID No:

Gender: (Mark with an X) M F

PATIENT DETAILS

Patient Surname:

Patient First Name:

Patient ID/Passport Number:

Date of Birth:

Postal Address:

Postal Code:

Email Address:

Telephone Number (W):

Cell Number:

Fax Number:

Gender: (Mark with an X) M F Dependant Code:

I, _____ (patient's name and surname) the undersigned, declare that:

a) I understand that all personal clinical information supplied to the PMB programme will be used to determine access to specific benefits for PMB conditions.
b) The programme's Medical staff will review this information in order to make recommendations regarding the provision of these benefits. My/my dependant/s healthcare provider, however, retains responsibility for my/my dependant/s care, irrespective of the benefits so authorised.
c) I/we therefore authorise any healthcare provider, hospital, clinic, laboratory and/or medical facility in possession of any medical information. regarding myself (the applicant) or any dependant (including new born baby), to provide the PMB programme with information that it may require.
d) I warrant that the information in this application form is correct. I acknowledge that I will be responsible for any co-payments as per Scheme Rules or payment for any medication and/or investigations not authorised by the PMB team.
e) I understand and agree that medical information relevant to my current state of health can be used for the purpose of scientific, epidemiological and/or financial analysis without disclosure of my identity.
f) I acknowledge that benefits authorised by the PMB programme are subject to Managed Care guidelines.
g) I am aware that more information on the PMBs can be obtained from the Scheme and the Council for Medical Schemes (CMS).

Principal Member Signature: _____ Date:

SECTION B TREATING HEALTHCARE PROVIDER DETAILS

Title:		Initials:	
Provider Surname:			
Practice Number:			
Postal Address:			
Postal Code:			
Physical Address:			
Email Address:			
Telephone Number (W):			
Cell Number:			
Fax Number:			

SECTION C TREATMENT (to be completed by the Healthcare Provider)

CLINICAL HISTORY

Please specify the condition for which you are requesting access to PMB benefits.

Condition	ICD-10 Code	Is the patient currently on medication?		When was diagnosis first made?
		Y	N	YEAR
		Y	N	YEAR
		Y	N	YEAR

TREATMENT PLAN

Condition	Procedure or consultation NHRPL tariff code	Number of procedures or consultations required per year	Number of procedures or consultations required per year

ACUTE MEDICATION

Condition	Drug Name	Drug Strength	Period Required	Quantity

Note: Chronic Medicine to be authorised via the Chronic Medicine Management process:
Effective 1 June 2019: Tel: 086 000 2120 (member and provider) Email: medshieldauths@mediscor.co.za

CLINICAL MOTIVATION

Please provide a brief outline of the reason for application.

TREATMENT PLAN

Condition	Date of Test	Name of Test	Result

Date:

HEALTHCARE PROVIDER'S STAMP

If no Stamp is available, please mark this block with an X.

Healthcare Provider's Signature: _____

SECTION D MOTIVATION TO WAIVE NON-DSP RULES

A DSP is a healthcare provider or group of providers who have been selected by the Scheme to deliver the diagnosis, treatment and care in respect of PMB conditions to its members.

If you choose to use a healthcare provider other than the DSP for the treatment of a PMB condition, the Scheme may impose a co-payment or limit the rate at which claims are reimbursed.

Please select one of the reasons below for the waiver of the non-DSP rule:

- ☐ Service not available from DSP/could not be provided without unreasonable delay
- ☐ Immediate (emergency) treatment required under circumstances where DSP could not be readily accessed
- ☐ DSP not within reasonable proximity

Additional information in support of request:
Please note that an application to waive the non-DSP rule will not be considered unless sufficient proof is provided that treatment at the DSP could not be reasonably accessed.

PLEASE FAX FORM TO +27 10 597 4706, EMAIL: PMBApplications@medshield.co.za