

# PMB PROGRAMME APPLICATION FORM

Fmail: PMBApplications@medshield.co.za

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Please complete in black ink. F Mark with an X where necessar		•	_	•			•	ne ch	aracte	er per	block	. Leav	e one	e bloci	k betv	ween	words	3.			
Membership Number:																					
SECTION A	M	IEME	BERS	HIP [	DETAI	LS															
Principal Member Surname:																					
Principal Member First Names	s·																				
Principal Member ID No:	<b>.</b>																				
Gender: (Mark with an X)			<u> </u> И		<u> </u> F																
DATIFAL DETAIL C																					
PATIENT DETAILS																					
Patient Surname:																					
Patient First Name:																					
Patient ID/Passport Number:																					
Date of Birth:	D	D	M	M	Υ	Υ	Υ	Υ				,									
Postal Address:																					
Postal Code:																		•			
Email Address:																					
Telephone Number (W):	С	0	D	Е										ı				1			
Cell Number:												_									
Fax Number:	С	0	D	Е																	
Gender: (Mark with an X)	ı	M		F		D	epend	dant C	ode:												
a) I understand that all personal c	linica	l inforr	nation	supp	lied to	the P	MB pr						ne) the rmine		-				r PMB	cond	itions.
b) The programme's Medical staff												-	-	•					ly/my		
dependant/s healthcare provider, c) I/we therefore authorise any he								-											ı. rega	rding	
myself (the applicant) or any depe		•	_													-			- D. I		
<ul> <li>d) I warrant that the information in payment for any medication and/</li> </ul>								•		WIII DE	erespo	onsible	e tor a	пу со-	paym	ents a	is per	Schen	ne Rui	es or	
e) I understand and agree that me				releva	ant to r	ny cu	rrent s	tate o	f healt	h can	be us	ed for	the pu	ırpose	of sc	ientific	c, epic	demiol	ogical	and/o	r
financial analysis without disclosurable f) I acknowledge that benefits aut		-	-	/IB pro	ogramı	ne ar	e subi	ect to	Mana	ged C	are au	iideline	es.								
g) I am aware that more informati		-			-		-			_	_			al Sch	nemes	(CMS	S).				
Principal Member Signature												Date	e:	D	D	М	M	Υ	Υ	Υ	Υ

SECTION B	TREATING HEALTHCARE PROVIDER DETAILS															
ŗ					,						1					
Title:						In	itials:									
Provider Surname:																
Practice Number:				-				-								
Postal Address:																
Postal Code:										•	•					
Physical Address:																
Email Address:																
Telephone Number (W):	С	0	D	Е												
Cell Number:											,					
Fax Number:	С	0	D	Е												
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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 patie on med	nt currently ication?	When was diagnosis first made?		
		Υ	N	YEAR		
		Υ	N	YEAR		
		Υ	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 ap	oplication.		

### TREATMENT PLAN

Condition	Date of Test	Name of Test	Result

HEALTHCARE PROVIDER'S STAMP

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

Healthcare Provider's Signatul	re:
SECTION D	MOTIVATION TO WAIVE NON-DSP RULES
A DSP is a healthcare provider respect of PMB conditions to it	or group of providers who have been selected by the Scheme to deliver the diagnosis, treatment and care in tempers.
If you choose to use a healthca limit the rate at which claims ar	are provider other than the DSP for the treatment of a PMB condition, the Scheme may impose a co-payment or re reimbursed.
Please select one of the reason	ns below for the waiver of the non-DSP rule:
Service not available from	m DSP/could not be provided without unreasonable delay
Immediate (emergency) t	treatment required under circumstances where DSP could not be readily accessed
DSP not within reasonab	ple proximity
Additional information in sup Please note that an application could not be reasonably access	to waive the non-DSP rule will not be considered unless sufficient proof is provided that treatment at the DSP

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