

Appeal for out-of-hospital treatment over and above that provided by the Prescribed Minimum Benefits 2020



Contact us

Tel: 0860 100 698 • PO Box 8012, Greenstone, 1616 • www.malcormedicalaid.co.za

Who we are

The Malcor Medical Aid Scheme (referred to as 'the Scheme'), registration number 1547, 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.

About this form

This form should be completed when a member needs out-of-hospital treatment that falls outside of the basic level of care provided for in the Prescribed Minimum Benefits.

Please only complete this form if we have already reviewed a request for funding for your condition as a Prescribed Minimum Benefit. Otherwise please refer to the Application for out-of-hospital management of a Prescribed Minimum Benefit condition.

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 and 2 of this form.
3. Your Healthcare Professional must complete section 3 and 4 and included detailed documents to support this application for acute and/or ongoing treatment for a Prescribed Minimum Benefit.
4. Please fax this completed and signed form with any supporting documents to 011 539 2780 or email it to **PMB_APP_FORMS@malcormedicalaid.co.za**
5. You will receive a letter informing you of our decision and the process you should follow.
6. You may call us if you would like to lodge a formal dispute to a declined appeals decision.

The latest version of the application form is available on www.malcormedicalaid.co.za. Alternatively, members can call 0860 100 698 and healthcare professionals can call 0860 44 55 66 for us to send the latest form.

1. Patient details

Name and surname	<input type="text"/>	
Date of birth	<input type="text"/>	Identity 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 me by Email Fax

2. Notes to member

I give permission for my healthcare provider to provide Malcor Medical Aid Scheme with my diagnosis and other relevant clinical information required to review my application.

I consent to Malcor Medical Aid Scheme and Discovery Health (Pty) Ltd disclosing from time to time, information supplied to Malcor Medical Aid 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 Discovery Health 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 Malcor 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 interventions and periodic review and this may include access to my medical records.
4. Treatment approved as a Prescribed Minimum Benefit will only be effective from when Malcor Medical Aid Scheme 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 Malcor Medical Aid Scheme or Discovery Health (Pty) Ltd asks for this.

Please note that this form expires on 2021/03/31. Up to date forms are always available on www.malcormedicalscheme.co.za

2. Notes to member (continued)

6. Consent for processing my personal information

- 6.1 I give the Scheme and 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's signature

Date

Y	Y	Y	Y	M	M	D	D
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(if patient is a minor, main member to sign)

I acknowledge that I have read and understood the conditions under "Notes to member" (section 2).

3. Application (healthcare professional to complete)

3.1 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 for us to review the application.

Please attach any relevant supporting documents, for example pathology tests.

When applying for mental health conditions for all children below the age of 13, please submit a DSM IV or V form including the GAF (global assessment of functioning) score.

3.2 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

3.3 Application for radiology

Condition	ICD-10 code	Description of investigation	Quantity per year

3.4 Application for pathology

Condition	ICD-10 code	Description of investigation	Quantity per year

4. 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

Please note that this form expires on 2021/03/31. Up to date forms are always available on www.malcormedicalscheme.co.za

Malcor Medical Aid Scheme is a registered medical scheme with the Council for Medical Schemes (CMS). The CMS contact details are as follows: e-mail: complaints@medicalschemes.com / Customer Care Centre: 0861 123 267 / website: www.medicalschemes.com

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