Request for additional cover for out-of-hospital Prescribed Minimum Benefit conditions 2024

MALCOR MEDICAL AID SCHEME
Administered by Discovery Health

Contact details
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.

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 sections 3 and 4 and include 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 for claims submission.
6. You may call us if you would like to lodge a formal dispute to a declined decision.

1. Patient details

Title | Initials

First name(s)

Surname

Membership number

ID or passport number

Telephone (H) | Telephone (W)

Cellphone

Email

Relationship to main member

2. Notes to member

Member's acceptance and permission

I give permission for my healthcare provider to provide Malcor Medical Scheme and the administrator with my diagnosis and other relevant clinical information required to review my application. I agree to my information being used to develop registries. This means that you give permission for us to collect and record information about your condition and treatment. This data will be analysed, evaluated and used to measure clinical outcomes and make informed funding decisions.
I understand that:

2.1. Funding from Prescribed Minimum Benefits is subject to meeting benefit entry criteria as determined by Malcor Medical Scheme and the administrator.
2.2. The Prescribed Minimum Benefit provides cover for disease-modifying therapy only, which means that not all medicines for a listed condition are automatically covered by Prescribed Minimum Benefits.
2.3. By registering for Prescribed Minimum Benefits, I agree that my condition may be subject to disease management interventions and periodic review and that this may include access to my medical records.
2.4. Funding for treatment from Prescribed Minimum Benefits will only be effective from when Malcor Medical Scheme or the administrator receives an application form that is completed in full.

2.5. An application form needs to be completed when applying for a new PMB condition.

2.6. If you are approved on the benefit, you need to let us know when your treating doctor changes your treatment plan so that we can update your Prescribed Minimum Benefit authorisation/s. You can do this by emailing the new prescription to us or asking your doctor or pharmacist to do this for you.

2.7. To make sure that we pay your claims from the correct benefit, we need the claims from your healthcare providers to be submitted with the relevant ICD-10 diagnosis code(s). Please ask your doctor to include your ICD-10 diagnosis code(s) on the claims they submit and on the form that they complete when they refer you to the pathologists and/or radiologists for tests. This will enable the pathologists and radiologists to include the relevant ICD-10 diagnosis code(s) on the claims they submit, ensuring that we pay your claims from the correct benefit.

Consent for processing my personal information

I give the Scheme and the administrator consent to have access to and process all information (including general, personal, medical or clinical information) that is relevant to this application. I understand that this information will be used for the purposes of applying for and assessing my funding request for Prescribed Minimum Benefits. I consent to the Scheme and the administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical information) to my healthcare provider and to relevant third parties, to administer the Prescribed Minimum Benefits as well as undertake managed care interventions related to the PMB condition. Withdrawing consent for your general, personal, medical or clinical information to be accessed or shared with relevant third parties, means that you will no longer have access to funding from the applicable disease management benefits. Claims which would usually be funded from the disease management benefits will, once consent is withdrawn, be funded from other available benefits according to the rules of your plan. Should you wish to withdraw consent, then please call **0860 100 698**.

Patient's signature

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

Date Y Y Y Y M M D D

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 medical treatment

Condition	ICD-10 Code	Consultation or procedure code**	Consultation and procedure description	Quantity required

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 documentation, for example pathology tests.

When applying for mental health conditions over and above the sessions provided for, please submit a DSM 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 when necessary)

Condition	ICD-10 code	Medicine name, strength and dosage	How long has the patient used this medicine?	
			Years	Months

3.3. Application for radiology

Condition	ICD-10 code	Procedure code	Description of investigation	Quantity required

3.4. Application for pathology

Condition	ICD-10 code	Procedure code	Procedure description	Quantity required

4. Doctor's details

Name and surname

BHF practice number

Speciality

Telephone

Fax

Email address

Notes to doctor

4.1. Please ensure that the relevant ICD-10 diagnosis code(s) are used when you submit your claims to the Scheme to ensure payment from the correct benefit.

4.2. Please include the ICD-10 diagnosis code(s) when referring your patient to the pathologists and/or radiologists. This will enable the pathologists and radiologists to include this information on their claims and allow us to comply with legislation by paying Prescribed Minimum Benefits (PMB) claims correctly.

4.3. We will approve funding for generic medicine, where available, unless you have indicated otherwise.

4.4. Please submit all the requested supporting documents with this application to prevent delays in the review process.

4.5. Should you make changes to your patient's treatment plan, you need to let us know so that we can update their PMB authorisation/s. You can do this by emailing the new prescription to us. If you or your patient do not let us know about changes to the treatment plan, we may not pay claims from the correct benefit.

Doctor’s signature

Date D D M M Y Y Y Y