Request for additional cover for Chronic Disease List (CDL) conditions registered on the Chronic Illness Benefit (CIB) 2024

MALCOR MEDICAL AID SCHEME
Administered by Discovery Health

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

Please complete this form if you want to request additional cover for your approved Chronic Disease List (CDL) condition.

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.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. Email the completed and signed form to CIB_app_forms@malcormedicalaid.co.za
3. To avoid administrative delays, please ensure this form is completed in full by you and your doctor.

1. About the patient (member to complete if patient is a minor)

Name and Surname

ID / passport number | Membership number

Telephone | Cellphone

Email address

The outcome of this application will be sent to you by email.

I give consent to Malcor Medical Aid Scheme and Discovery Health (Pty) Ltd to use the above communication channel for all future communication.

Patient's signature
(if patient is a minor, main member to sign)

2. Request for additional consultations and procedures (doctor to complete)

Your patient has automatic access to an annual treatment basket containing a limited number of consultations and procedures when approved for a PMB CDL condition. Please complete the table below where the request is for further cover or for consultations or procedures not included in the treatment basket.

Condition	Consultation or procedure code	Number of consultations or procedures required per year	Supporting information for the request

3. Request for cover in full for non-formulary medicine (doctor to complete)

Please complete the table below where non-formulary medicine is prescribed for the treatment of PMB CDL conditions and the request is for cover without a co-payment. Please supply additional information and supporting documentation where appropriate, as to why the formulary medicine cannot be used by the patient, including details of treatment failure or adverse drug reactions where applicable.

Medicine name and strength	Quantity	Supporting information for the request

Previous Medicine history

Medicine name and strength	Date treatment with this medicine was initiated	How long did the patient use the medicine for?	Details of treatment failure or adverse drug reactions

4. Doctor's details (doctor to complete)

Name and surname

Practice Number

Speciality

Telephone

Email

The outcome of this application will be communicated to you by email.

Doctor's signature

Date Y Y Y Y M M D D