Fax Cover Sheet

To	ezelle	**From**	
Company		**Company**	Discovery Health
Telephone Number		**Telephone Number**	
Fax Number	0865116324	**Fax Number**	
Number of pages (including cover page)	03	**Date**	Monday, February 21, 2011
Subject			

Discovery Health

Contact us
Tel: 0860 99 88 77, PO Box 784262, Sandton, 2146, www.discovery.co.za

Prescribed Minimum Benefits (PMB) Chronic Disease List (CDL) application form

Please complete this form if you want to apply for extra cover for the diagnosis of, medicine for, or out-of-hospital management of a Prescribed Minimum Benefit (PMB) condition

How to complete this form

- Please use one letter per block, complete with black ink and print clearly.
- Fax the completed and signed form to **011 539 7011** or post it to Discovery Health, Chronic Illness Benefit, PO Box 652919, Benmore, 2010.
- As a member, please complete section 1 of this form.
- Your doctor must complete section 2 and 3, and include detailed documents supporting your application.
- You will receive a letter informing you of our decision and the process to be followed for approved requests.

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

Title Initials Surname

First name

ID number Date of birth

Membership number

Postal address

Code

Telephone (H) (W)

Cellphone Fax

Email address

Name of patient (if a minor)

May we communicate your confidential information to you at this email address Yes ☐ No ☐ or fax number Yes ☐ No ☐

Has your condition been approved on the Chronic Illness Benefit? Yes ☐ No ☐

If **yes**, your doctor must list the condition for which you are approved on the next page.

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2. Application (doctor to complete)

2.1 Application for out-of-hospital medical management

Condition	Consultation or procedure code	Motivation and number of extra consultations or procedures

2.2 Application for medicine

Request for current medicine (please provide details and relevant laboratory tests to show success of therapy example blood pressure reading or HBA1C)

Condition	Medicine name, strength and dosage	Quantity each month	Is the patient controlled? (Please attach relevant details)

2.3 Previous medicine history

Medicine	Date medicine started	Length of therapy	Side effects experienced*	Lack of efficacy**

* Please provide details and severity

** Please provide details and attach laboratory test where appropriate

3. Doctor's details (doctor to complete)

Name of doctor

BHF practice number Speciality

Fax

Email

Date 2 0

Doctor's signature

The outcome of this application must be communicated to me through my email address Yes ☐ No ☐ or fax number Yes ☐ No ☐