BMW Employees Medical Aid Society

Administered by Discovery Health

**Contact details**
Tel: 0860 002 107 • PO Box 652509, Benmore 2010 • www.bemas.co.za

# HIV PMB application form

**Request for additional cover from the Prescribed Minimum Benefits**

This form is valid for 2020, the latest version of the application form is available on www.bemas.co.za

**Who we are**
The BMW Employees Medical Aid Society (referred to as 'BEMAS'), registration number 1526, is a not-for-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 BEMAS.

Patient name and surname

Membership number

**How to complete this form**
1. Please use one letter per block, complete in black ink and print clearly.
2. Please complete this form if you wish to apply for additional cover for the diagnosis of, medicine for, or out-of-hospital management of a Prescribed Minimum Benefit (PMB) condition.
3. You (the member) must complete Section 1 and Section 2 of this form.
4. Your doctor must complete Section 3 and Section 4, and include detailed documents supporting your application.
5. Please fax this completed and signed form with any support documentation to 011 539 3151 or email it to **HIV_Diseasemanagement@discovery.co.za** or post it to **BMW Employees Medical Aid Society, PO Box 536, Rivonia, 2128.**
6. A dedicated case manager will call you and your treating doctor let you know about our funding decision and the process to follow if your application is approved.
7. You can also contact our call centre on 0860 002 107 if you have any questions.
8. To avoid administration delays, please ensure this application is completed in full.

## 1. Main member details

Title | Initials

Surname

Membership number | Date of birth D D M M Y Y Y Y

Postal address

Code

Telephone (H) - | (W) -

Cellphone - | Fax -

Email

## 2. About the patient

Title | Initials

Surname

ID or passport number

Membership number | Date of birth D D M M Y Y Y Y

Postal address

Code

Telephone (H) - | (W) -

Cellphone - | Fax -

Email

May we communicate your information to you by email or fax

Relationship to main member

Patient's signature | Date D D M M Y Y Y Y

## 3. Information about treatment request *(doctor to complete)*

### 3.1. Application for medical management

Out-of-hospital

| Condition | RPL consultation or procedure code | RPL description | Number of consultations or procedures per year |
|---|---|---|---|
| | | | |
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### 3.2. Application for medicine

**Current medicine requested *(please provide details)***

| Condition | Medication name, strength and dosage | NAPPI code | Frequency |
|---|---|---|---|
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### 3.3. Application for radiology

| Condition | Code | Description | Quantity |
|---|---|---|---|
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### 3.4. Application for pathology

| Condition | Code | Description | Quantity |
|---|---|---|---|
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## 4. Doctor's details *(doctor to complete)*

Name

BHF practice number

Fax -

Doctor's signature

Date D D M M Y Y Y Y