



Contact details

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

Oncology PMB application form

Request for additional cover from the Prescribed Minimum Benefits

Who we are

The BMW Employees Medical Aid Society (referred to as 'BEMAS'), registration number 1526, is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as 'we' 'us' and 'our' or 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's name and surname																	
Membership number																	

How to complete this form

Please sign the form and ensure that all the relevant information required, as set out in the form is completed, including contact details for the provider and date of request.

- 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 of this form.
- 4. Your doctor must complete Section 2 and Section 3, and include detailed documents supporting your application.
- 5. Please fax this completed and signed form with any supporting documents to **011 539 5417** or post it to **Discovery Health, Oncology, PO Box 784262, Sandton 2146.** You can also contact our oncology call centre on 0860 002 107 if you have any questions. You will receive a letter informing you of our decision and the process to follow for approved requests.
- 6. You may call us if you would like to lodge a formal dispute to a declined appeals decision.

1. About yourse	If (main applicant)
Title	Initials Surname Surname
ID number	
Membership number	Date of birth Y Y Y M M D D
Postal address	
	Code
Telephone (H)	(w)
Cellphone	Fax
Email address	
Name of patient or d	ependant
May we communicate	e your information to you by: email 🗌 or fax 🦳
Has your treatment b	peen approved on the Oncology Benefit? Yes No No
If yes , your doctor me	ust list the condition for which your treatment has been approved on the next page.

2. Information	about treatment request (doctor to complete)		
Diagnosis (incl. descr	iption) D	ate of Diagnosis: Y	Y Y M M D D
Primary ICD 10 code:	S	econdary ICD code/s:	
Diagnostic	Ongoing Treatment/Monitoring		
	nedical management which may include Pathology, Radiology and other condition uests: Initial requests will need to be accompanied by a valid script, thereafter a s		
Date of service	Procedure code (NHRPL code)/ Treatment	Frequency/ Quantity	Claim related? Y/N (Please provide the date of service)
3. Doctor's deta	ails (doctor to complete)		
Name			
Practice number	Speciality		
Email			
Doctor's signature		Date Y Y	Y Y M M D D
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- 1. You will be required to submit an Oncology PMB application form in instances where a member has exhausted his/her benefits from the Oncology Basket of Care.
- 2. If the appeal has been approved, we will forward communication to you and the claim will be sent for re-processing.
- 3. **Important to note:** If the member still has sufficient benefits available, we will not provide you with an authorization number as per our internal process.
- 4. You will also be requested to submit an Oncology PMB Application Form in instances where the item is not part of the Oncology Basket of Care available.

Please note, the submission of an Oncology PMB Application Form does not guarantee payment.