

**Contact details**

Tel: 0860 002 107 • PO Box 652509, Benmore 2010 • [www.bemas.co.za](http://www.bemas.co.za)

## Pre-assessment request

### 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 '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.

### When you sign this pre-assessment request you confirm that information provided is true and correct.

When you sign this form, you are requesting BMW Medical Aid Society to provide you with a quotation for a procedure you or a dependant is scheduled to have. This will enable you to compare the costs that your service providers have given you, with what your health plan will pay.

**Please note:** You need to obtain an authorisation number from the preauthorisations department first before we can assist you with a preassessment request. To authorise the procedure, please call 0860 002 107. You will need the following information when you contact our preauthorisations department:

- Date of service
- Treatment and ICD-10 codes
- Practice numbers for the hospital and the treating doctor

Your doctor can provide you with this information.

If you have any questions, please let us know. Once we have assessed your request, we will provide you with a quote letter.

### How to complete this form

- Please use one letter per block, complete in black ink and print clearly.
- To avoid unnecessary delays, please
  - complete all sections. We cannot provide you with a pre-assessment if section 5 is not completed.
  - include all information, including the authorisation number
- Fax the completed and signed form to **011 539 1044** or email it to **PREASSESSMENT\_REQUESTS@discovery.co.za**

## 1. Important details about pre-assessments

### A pre-assessment helps you to understand your cover and any shortfalls you may have to pay

- With a completed pre-assessment, you are able to compare the costs that your service provider charged with the costs that your health plan will cover. It helps you to understand any financial implications beforehand.
- A pre-assessment is a quote and does not guarantee payment.

### A pre-assessment is done on request and you need to ask for it before having the procedure

- We will only do a pre-assessment before the procedure is done and we have issued an authorisation.
- We need at least seven working days to complete the assessment.

### A pre-assessment does not replace the authorisation you need from the Society

- This is only a guideline for costs and what the Society will pay according to your plan type and Society Rules – you still need to obtain the relevant authorisation before the procedure is done.
- Please note that we will only pay for the codes received according to this quote. If your doctor changes or adds codes to this quote, we cannot accept any responsibility for the difference in cover.

### We will send a completed assessment letter to you

- Because the information in a pre-assessment form is confidential, we will send the completed assessment letter to you only.
- We will send the completed assessment letter using the preferred communication channel given in this form. If you do not give us an email address or fax number or if the details do not belong to you, we will post it to the address we have on our records for you.

### Contact us if you have any questions about this pre-assessment form

If you need to check or query anything about this application, please call us on 0860 002 107.

## 2. About the main member

Membership number	<input type="text"/>		
Surname	<input type="text"/>		
First names	<input type="text"/>		
ID or passport number	<input type="text"/>	Country of issue	<input type="text"/>

BEMPR001

**Postal address (Post collected from post box, suite or private bag)**

PO Box  Private bag  Box number   
 Suite  Postnet Suite  Number   
Suburb  Postal code

**Physical address**

Suite or unit number  Complex name   
Street number  Street name   
Suburb  Postal code   
Telephone (H)  (W)   
Cellphone   
Email

Please choose a date you want cover to start for all dependant/s you are applying for. This date must be the same for all your dependant/s applying for cover.

Cover start date

**3. Patient details**

Title  Initials   
First name(s) (as per identity document)   
Relationship to main member   
How would you prefer to receive the assessment letter? Email  Fax  Post   
Will the procedure be done in- or out-of-hospital? In  Out   
Was a benefit authorisation number requested for the procedure from the Society? Yes  No   
If yes, please provide the benefit authorisation number

**4. Doctor or healthcare professional's details**

Name   
Billing practice number   
Treating practice number  Contact number   
Date of treatment

**5. Details about the procedure**

When will procedure be done?   
Where will the procedure be done? In hospital or day clinic  Other facility instead of in hospital   
Please give authorisation number for this procedure

**Procedure information**

Please provide a separate rand value for each procedure code. We will not be able to assess estimated or combined amounts.

**Codes from your healthcare professional**

We need the treatment and procedure codes to make sure we all refer to the same procedures and products. Please provide the ICD-10 diagnosis code and all the procedure and product codes.

(An ICD-10 code describes your diagnosis and contains numbers and letters, for example Tonsillitis could be coded as J35.0. An ICD-10 code may be 3, 4 or 5 characters in length. Procedure codes are 4-5 digits long and product codes are 6-9 digits long).

ICD-10 diagnosis code:

Practice number	Procedure code	Rand value		Practice number	Procedure code	Rand value

**Please note:**

If your healthcare professional gave you more codes than there are lines available on this form, you can attach extra pages. If you do add a page, it is very important that you include the practice number, codes and rand values for every code. You can also attach the quotations you received from your healthcare professionals to this form, but please make sure that the practice numbers, procedure codes and rand values are included for every code on the quotation.

Signed at (town or city)  on 

D	D	M	M	Y	Y	Y	Y
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Signature of main member

**Please do not sign an incomplete form**