ANGLOVAAL GROUP MEDICAL SCHEME

Administered by Discovery Health

Contact details
Tel: 0860 100 693 • PO Box 652509, Benmore 2010 • www.avgms.co.za

Appeal for out-of-hospital treatment over and above that provided by the Prescribed Minimum Benefits 2019

Who we are

The Anglovaal Group Medical Scheme (referred to as 'the Scheme'), registration number 1571, 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.

The latest version of the application form is available on www.avgms.co.za. Alternatively, members can call 0860 100 693 and healthcare professionals can call 0860 44 55 66 for us to send the latest form.

About this form

This form should be completed when a member needs out-of-hospital treatment that falls outside of the basic level of care provided for in the Prescribed Minimum Benefits.

Please only complete this form if we have already reviewed a request for funding for your condition as a Prescribed Minimum Benefit.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. You (the member) must complete sections 1 and 2 of this form.
3. Your Healthcare Professional must complete section 3 and 4 and included detailed documents to support this application for acute and/or ongoing treatment for a Prescribed Minimum Benefit.
4. Please fax this completed and signed form with any supporting documents to 011 539 2780 or email it to **PMB_APP_FORMS@discovery.co.za**
5. You will receive a letter informing you of our decision and the process you should follow for claims submission.
6. You may call us if you would like to lodge a formal dispute to a declined appeals decision.

1. Patient details

Name and surname

Date of birth (Y Y Y Y M M D D) Identity number

Membership number

Telephone (H) (W)

Cellphone Fax

Email address

Relationship to main member

The outcome of this application can be communicated to me by Email ☐ Fax ☐

2. Notes to member

I give permission for my healthcare professional to provide Anglovaal Group Medical Scheme with my diagnosis and other relevant clinical information required to review my application for Prescribed Minimum Benefits. I consent to Anglovaal Group Medical Scheme and Discovery Health (Pty) Ltd disclosing from time to time, information supplied to Anglovaal Group Medical Scheme and Discovery Health (Pty) Ltd (including general or medical information that is relevant to my application) to my healthcare provider, to administer my benefits. I agree that Anglovaal Group Medical Scheme may disclose this information at its discretion but only as long as all the parties involved have agreed to always keep the information confidential. I understand that:

1. Funding from the Prescribed Minimum Benefit is subject to benefit entry requirements as determined by Anglovaal Group Medical Scheme.
2. Each case will be assessed on its own merit.
3. By registering for the Prescribed Minimum Benefits, I agree that my condition may be subject to disease management interventions and periodic review and this may include access to my medical records.
4. Treatment approved as a Prescribed Minimum Benefit will only be effective from when Anglovaal Group Medical Scheme receives an application form that is completed in full.
5. The covered Prescribed Minimum Benefit conditions and benefit entry requirements may change from time to time and I may need to send an updated or new application form if Anglovaal Group Medical Scheme asks for this.

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

I acknowledge that I have read and understood the conditions under "Notes to member" (section 2).

3. Application (healthcare professional to complete)

3.1 Application for out-of-hospital medical management*

Condition	ICD-10 code	Consultation or procedure code**	Motivation	Quantity

*Please clearly specify what is required, for example consultations, pathology, radiology and/or procedure.
**The professional billing codes must be supplied for us to review the application.

Please attach any relevant supporting documents, for example pathology tests.
When applying for mental health conditions for all children below the age of 13, please submit a DSM IV or V form including the GAF (global assessment of functioning) score.

3.2 Application for medicine

Current medicine required (please provide supportive clinical results or information)

Condition	ICD-10 code	Medicine name, strength and dosage	Number of months

3.3 Application for radiology

Condition	ICD-10 code	Description of investigation	Quantity per year

3.4 Application for pathology

Condition	ICD-10 code	Description of investigation	Quantity per year

4. Healthcare professional's details

Name and surname

Practice number

Speciality

Telephone

Fax

Email address

Outcome of this application must be sent to me by Email ☐ Fax ☐

Healthcare professional's signature

Date Y Y Y Y M M D D

5. Disclaimer

The healthcare professional's fee for completion of this form will be reimbursed on code 0199, on submission of a separate claim. Payment of the claim is from the Medical Savings Account (if applicable to the member's plan option), subject to Scheme rules and availability of funds.

In line with legislative requirements, please make sure that when using code 0199, you submit the ICD-10 diagnosis code/s. As per industry standards, the appropriate ICD-10 code/s to use for this purpose would be those reflective of the actual Prescribed Minimum Benefit condition/s for which the form was completed. If multiple Prescribed Minimum Benefit conditions were applied for, then it would be appropriate to list all the relevant ICD-10 codes.

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