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 2020

Who we are
The Anglovaal Group Medical Scheme (referred to as 'the Scheme'), registration number 1571, 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 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.Otherwise please complete the "Application for out-of-hospital management of a Prescribed Minimum Benefit condition" form.

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 treatment of a Prescribed Minimum Benefit condition.
4. Please email completed and signed form with any supporting documents to PMB_APP_FORMS@discovery.co.za or fax it to 011 539 2780.
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.

1. Patient details

Name and surname

Date of birth D D M M Y Y Y Y ID Number

Membership number

Telephone (H) (W)

Cellphone Fax

Email

Relationship to main member

The outcome of this application must be sent 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 clinical entry criteria as determined by Anglovaal Group Medical Scheme and Discovery Health (Pty) Ltd.
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 or Discovery Health (Pty) Ltd receives an application form that is completed in full.
5. The covered Prescribed Minimum Benefit conditions and clinical entry criteria may change from time to time and I may need to send an updated or new application form if Anglovaal Group Medical Scheme or Discovery Health (Pty) Ltd asks for this.
6. Consent for processing my personal information
   6.1. I give the Scheme and Administrator consent to have access to and process all information (including general, personal, medical or clinical information) that is relevant to this application.
   6.2. I understand that this information will be used for the purposes of applying for and assessing my funding request for Prescribed Minimum Benefits.
   6.3. I consent to the Scheme and Administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical information) to my healthcare provider, to administer the Prescribed Minimum Benefits.

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

Date D D M M Y Y Y Y

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 treatment

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, where necessary)

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

3.3. Application for radiology

Condition	ICD-10 code	Medicine name, strength and dosage	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

Fax

Email address

Healthcare professional's signature

Date D D M M Y Y Y Y