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 2022

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

Member's acceptance and permission

I give permission for my healthcare provider to provide Anglovaal Group Medical Scheme and Discovery Health Medical Scheme with my diagnosis and other relevant clinical information required to review my application. I agree to my information being used to develop registries. This means that you give permission for us to collect and record information about your condition and treatment. This data will be analysed, evaluated and used to measure clinical outcomes and make informed funding decisions.
I understand that:

2.1. Funding from Prescribed Minimum Benefit is subject to meeting benefit entry criteria as determined by Anglovaal Group Medical Scheme and Discovery Health Medical Scheme.
2.2. The Prescribed Minimum Benefit provides cover for disease-modifying therapy only, which means that not all medicines for a listed condition are automatically covered by Prescribed Minimum Benefits.

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Please note that this form expires on 31/03/2023. Up to date forms are available on www.avgms.co.za.

2.3. By registering for Prescribed Minimum Benefits, I agree that my condition may be subject to disease management interventions and periodic review and that this may include access to my medical records.
2.4. Funding for treatment from Prescribed Minimum Benefit will only be effective from when Anglovaal Group Medical Scheme and Discovery Health Medical Scheme receives an application form that is completed in full.
2.5. An application form needs to be completed when applying for a new PMB condition.
2.6. If you are approved on the benefit, you need to let us know when your treating doctor changes your treatment plan so that we can update your Prescribed Minimum Benefit authorisation/s. You can do this by e-mailing the new prescription to us or asking your doctor or pharmacist to do this for you.
2.7. To make sure that we pay your claims from the correct benefit, we need the claims from your healthcare providers to be submitted with the relevant ICD-10 diagnosis code(s). Please ask your doctor to include your ICD-10 diagnosis code(s) on the claims they submit and on the form that they complete when they refer you to the pathologists and/or radiologists for tests. This will enable the pathologists and radiologists to include the relevant ICD-10 diagnosis code(s) on the claims they submit, ensuring that we pay your claims from the correct benefit.

Consent for processing my personal information
I give the Scheme and the administrator consent to have access to and process all information (including general, personal, medical or clinical information) that is relevant to this application. I understand that this information will be used for the purposes of applying for and assessing my funding request for Prescribed Minimum Benefits. I consent to the Scheme and the administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical information) to my healthcare provider and to relevant third parties, to administer the Prescribed Minimum Benefits as well as undertake managed care interventions related to the PMB condition.

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**	Consultation or procedure description	Quantity required

*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 over and above the sessions provided for, please submit a DSM 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	How long has the patient used this medicine?	
			Years	Months

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3.3. Application for radiology

Condition	ICD-10 code	Medicine name, strength and dosage	Quantity required

3.4. Application for pathology

Condition	ICD-10 code	Procedure code	Procedure description	Quantity required

4. Healthcare professional's details

Name and surname

BHF practice number

Speciality

Telephone

Fax

Email address

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

Notes to Healthcare Professional

4.1. Please ensure that the relevant ICD-10 diagnosis code(s) are used when you submit your claims to the Scheme to ensure payment from the correct benefit.

4.2. Please include the ICD-10 diagnosis code(s) when referring your patient to the pathologists and/or radiologists. This will enable the pathologists and radiologists to include this information on their claims and allow us to comply with legislation by paying Prescribed Minimum Benefits (PMB) claims correctly.

4.3. We will approve funding for generic medicine, where available, unless you have indicated otherwise.

4.4. Please submit all the requested supporting documents with this application to prevent delays in the review process.

4.5. Should you make changes to your patient's treatment plan, you need to let us know so that we can update their PMB authorisation/s. You can do this by e-mailing the new prescription to us. If you or your patient do not let us know about changes to the treatment plan, we may not pay claims from the correct benefit.

Healthcare professional's signature

Date