



Contact details

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

HIV PMB application form

Request for additional cover from the Prescribed Minimum Benefits

Who we are

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

Patient Name and surname

Membership number

How to complete this form

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 email this completed and signed form with any support documentation to HIV_Diseasemanagement@discovery.co.za or fax it to 011 539 3151 or post it to **Anglovaal Group Medical Scheme, PO Box 536, Rivonia, 2128.**
6. A dedicated case manager will call you and your treating doctor let you know about our funding decision and the process to follow if your application is approved.
7. You can also contact our call centre on 0860 100 693 if you have any questions.
8. To avoid administration delays, please ensure this application is completed in full.

1. Main member details

Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
ID Number	<input type="text"/>		
Membership number	<input type="text"/>	Date of birth	<input type="text"/>
Postal address	<input type="text"/>		
		Code	<input type="text"/>
Telephone (H)	<input type="text"/>	(W)	<input type="text"/>
Cellphone	<input type="text"/>	Fax	<input type="text"/>
Email	<input type="text"/>		

2. About the patient

Title Initials Surname

ID Number

Membership number Date of birth

Postal address

 Code

Telephone (H) (W)

Cellphone Fax

Email

May we communicate your information to you by email or fax

Relationship to main member

Patient's signature Date

(if patient is a minor, main member to sign)

3. Information about treatment request (*doctor to complete*)

3.1. Application for medical management

Out-of-hospital

Condition	RPL consultation or procedure code	RPL description	Number of consultations or procedures per year

3.2. Application for medicine

Medicine requested (*please provide details*)

Condition	Medicine name, strength and dosage	NAPPI code	Frequency

3.3. Application for radiology

Condition	Code	Description	Quantity

3.4. Application for pathology

Condition	Code	Description	Quantity

Doctor's details (doctor to complete)

Name

Practice number

Doctor's signature

Fax

Date