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

Contact details
Tel: 0860 002 133 • PO Box 10436, Johannesburg, 2000 • www.sabmas.co.za

Who we are

SAB Medical Aid (referred to as 'the Scheme'), registration number 1209, is a non-profit organisation, registered with the Council for Medical Schemes.

3Sixty Health (Pty) Ltd, registration number 1978/001109/07, is an accredited administration and managed care service provider responsible for administration of your membership on behalf of the Scheme.

About this form

This form should be completed when a member requires 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

Please ensure that all the relevant information required, as set out in the form is completed, including contact details for the provider and date of request.

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 sections 3 to 4 and please include detailed documents supporting your application.
4. Please fax this completed and signed form with any detailed supporting documents to 010 593 2074 or email it to **OHPMBApplications@sabmas.co.za.**
5. Once we have processed your application, you will receive a letter informing you of our decision and the process you should follow
6. You may call us if you would like to lodge a formal dispute in response to a declined decision submitted.

1. Patient details (member to complete)

Name and surname

Date of birth D D M M Y Y Y Y   Identity Number

Membership number

Telephone (H)   Work

Cellphone   Fax

Email address

Relationship to principal member

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

2. Notes to members

I give permission for my healthcare provider to provide SAB Medical Aid and the administrator 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 SAB Medical Aid and the administrator.
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.
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 University of SAB Medical Aid or the administrator 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.

Patient's signature ____________________ Date | Y | Y | Y | Y | M | M | D | D |

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

I acknowledge that I have read and understood the conditions under "Notes to member".

3. Application (healthcare professional to complete)

3.1. Application for out-of-hospital treatment

Condition	Date of diagnosis	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 completed 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

3.3. Application for radiology

Condition	ICD-10 code	Procedure code	Procedure description	Quantity required

3.4. Application for pathology

Condition	ICD-10 code	Procedure code	Procedure description	Quantity required

4. Healthcare professional's details (healthcare professional to complete)

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 at PMB_APP@netcaremedicalscheme.co.za. 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 D D M M Y Y Y Y

South African Breweries Medical Aid is a registered medical scheme and regulated by the Council for Medical Schemes (CMS). The CMS contact details are as follows:
Email: complaints@medicalschemes.co.za | Customer Care Centre: 0861 123 267 | Website: www.medicalschemes.co.za

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