Request for additional cover for Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions

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

Please complete this form if you are on the SAB Medical Aid Essential or Comprehensive Option and would like to request additional cover for your approved Chronic Disease List (CDL) condition.

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.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. You must complete and sign Section 1 of this form.
3. Your doctor must complete Sections 2 and 3, sign Section 3, and include any documents that support your application.
4. Email the completed and signed form to chronicappeals@sabmas.co.za
5. To avoid administrative delays, please ensure this form is completed in full by you and your doctor.

1. Patient's details (member to complete if patient is a minor)

Name and Surname

ID number

Membership number

Telephone

Cellphone

Email address

The outcome of this application will be sent to you by email.

I give consent to SAB Medical Aid and 3Sixty Health (Pty) Ltd to use the above communication channel for all future communication.

Patient's signature

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

2. Request for additional consultations and procedures (doctor to complete)

Your patient has automatic access to an annual treatment basket containing a limited number of consultations and procedures when approved for a PMB CDL condition. Please complete the table below where the request is for further cover or for consultations or procedures not included in the treatment basket.

Condition	Consultation or procedure code	Number of consultations or procedures required per year	Supporting information for the request

3. Doctor's details (doctor to complete)

Name and surname

Practice number

Speciality

Telephone

Email

The outcome of this application will be sent to you by email.

Doctor's signature

Date D D M M Y Y Y Y