

APPLICATION FORM

PRESCRIBED MINIMUM BENEFIT (PMB) CARE PLAN

TO BE COMPLETED BY APPLICANT

MEMBER DETAILS:

MEMBERSHIP NUMBER

SURNAME

TITLE INITIALS

E-MAIL ADDRESS

PATIENT DETAILS:

NAME AND SURNAME

TITLE ID NUMBER OR DATE OF BIRTH

ADDRESS

E-MAIL ADDRESS

TELEPHONE (H) (W)
 (CELL)

I authorise my medical practitioner to furnish and/or disclose to the PMB Programme any fact relating to this application as well as any additional information that may be required from time to time.

MEMBER'S SIGNATURE _____

DATE

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

DOCTOR DETAILS:

SURNAME INITIALS

PRACTICE NUMBER SPECIALITY

TELEPHONE FAX

CELLPHONE

POSTAL ADDRESS CODE

E-MAIL ADDRESS

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER (CONTINUED)

ASSOCIATED SPECIALIST DETAILS:

NAME

PRACTICE NUMBER

 SPECIALITY

CLINICAL EXAMINATION:

MALE/FEMALE M F WEIGHT

 kg HEIGHT

 cm BLOOD PRESSURE

 /

SMOKING: NEVER EX-SMOKER <10 PER DAY >10 PER DAY

EXERCISE: NEVER <1 HOUR PER WEEK 1-3 HOURS PER WEEK >3 HOURS PER WEEK

ALLERGIES: PENICILLIN ASPIRIN SULPHONAMIDES

 OTHER

PLEASE NOTE THAT CLINICAL INFORMATION IS MANDATED PRIOR TO THE AUTHORISATION OF A PMB CARE PLAN AND WHEN ADDITIONAL SERVICES ARE REQUIRED.

AUTHORISED CHRONIC MEDICATION IN USE (Please use block letters)

ICD-10 Code(s)	Diagnosis	Name of medication	Strength (e.g. 50mg)	Directions (e.g. 2tds)

PRESCRIBED MINIMUM BENEFITS

Please indicate which condition(s) your patient has by placing an "X" next to the applicable condition.

Addison's Disease	Crohn's Disease	Hypertension
Asthma	Diabetes Insipidus	Hypothyroidism
Bipolar Mood Disorder	Diabetes Mellitus Type 1	Multiple Sclerosis
Bronchiectasis	Diabetes Mellitus Type 2	Parkinson's Disease
Cardiac Failure	Dysrhythmias	Rheumatoid Arthritis
Cardiomyopathy Disease	Epilepsy	Schizophrenia
Chronic Obstructive Pulmonary Disorder	Glaucoma	Systemic Lupus Erythematosus
Chronic Renal Disease	Haemophilia	Ulcerative Colitis
Coronary Artery Disease	Hyperlipidaemia	

Please take note of the following:

- The information contained in this application form is used to draw up your PMB Care Plan.
- Treatment and care is strictly for the 26 PMB Chronic Disease List (CDL) conditions. Please ensure that your treating doctor includes the correct ICD-10 codes to ensure that your claims are paid from the appropriate benefit.
- If you or your beneficiary is authorised for a PMB Care Plan during the course of the year; the services outlined in the Care Plan will be granted on a prorated basis.

I hereby acknowledge that the scheme has appointed Qualsa Healthcare (Pty) Ltd as the administrator of the programme and that any prescribed medical treatment shall be the sole responsibility of my medical practitioner.

I understand that the information provided on this form shall be treated as confidential and will not be used or disclosed except for the purpose for which it has been obtained.

Whilst Qualsa undertakes to take all reasonable precautions to uphold the confidentiality of information disclosed to it, I am aware that my medical scheme and practitioner (where necessary) shall also gain access to the same information. I shall therefore not hold Qualsa liable for any claims by me or my dependants arising from any unauthorised disclosure of my personal information to other parties.

I hereby certify that the information provided is true and correct.

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RETURN ADDRESS: DISEASE RISK MANAGEMENT PROGRAMME
61 ST GEORGE'S MALL, CAPE TOWN 8001 OR PO BOX 15079, VLAEBERG 8018
ENQUIRIES: TEL 021 480 4460 **EMAIL:** bpmasdrm@mhg.co.za