LA Health
Powered by Discovery

Contact details
Tel: 0860 103 933 • PO Box 652509, Benmore 2010 • www.lahealth.co.za

HIV PMB application form

Request for additional cover from the Prescribed Minimum Benefits

Patient name and surname

Membership number

How to complete this form

What you must do

Please go through these two steps:
Step 1: Fill in the form
Step 2: Sign the application form.

1. To avoid administration delays, please ensure this application is completed in full.
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 documentation supporting your application.
5. Please fax this completed and signed form with any support documentation to **011 539 3151** or email it to HIV_Diseasemanagement@discovery.co.za, or post it to **LA Health Medical Scheme, PO Box 652509, Benmore, 2010.** You can also contact our **call centre on 0860 100 417** if you have any questions.
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.

1. Main member 's details

Title Initials Surname

ID number

Membership number Date of birth Y Y Y Y M M D D

Postal address

Code

Telephone (H) (W)

Cellphone Fax

Email

2. About the patient

Title Initials Surname

ID number

Membership number Date of birth Y Y Y Y M M D D

Postal address

Code

Telephone (H) (W)

Cellphone Fax

Email

May we communicate your information to you by email ☐ or fax ☐

Relationship to main member

LA Health Medical Scheme, registration number 1145. Administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07. An authorised financial services provider

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

Current 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

4. Doctor's details *(doctor to complete)*

Name

BHF practice number

Fax

Doctor's signature

Date Y Y Y Y M M D D

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