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

Request for additional cover for Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions registered on the Chronic Illness Benefit (CIB)

Please complete this form if you want to appeal for extra cover for your approved Chronic Disease List condition.

How to complete this form

- Please use one letter per block, complete with black ink and print clearly.
- Fax the completed and signed form to 011 539 7000 or email it to **CIB_APP_FORMS@discovery.co.za**
- To avoid administration delays, please ensure this application is completed in full by you and your doctor.

1. About the patient (member to complete if patient is a minor)

Name and Surname

ID /passport number

Membership number

Telephone

Fax

Cellphone

Email address

Outcome of this application must be sent to me by Email ☐ Fax ☐

2. Appeal for consultations and procedures (doctor to complete)

A basket of care containing consultations and procedures is approved for patients on registration of 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 basket.
To view the baskets go to www.lahealth.co.za

Condition	Consultation or procedure code	Number of consultations or procedures per year	Motivation for the request

3. Appeal for medicine (doctor to complete)

Please complete the table below where non-formulary medicine is prescribed for the treatment of PMB CDL conditions and the request is for cover without co-payment. Please supply a clinical motivation and supporting documentation where appropriate, as to why the formulary medicine cannot be used by the patient, including details of treatment failure or adverse drug reactions where applicable

Medicine name and strength	Quantity	Is the patient's condition controlled?

Previous medicine history

Medicine name and strength	Date medicine was started	How long did the patient use the medicine for?	Details of treatment failure or adverse drug reactions

4. Doctor's details (doctor to complete)

Name and surname

Practice number Speciality

Telephone Fax

Email

Outcome of this application must be sent to me by Email ☐ Fax ☐

Doctor's signature Date 2 0 Y Y M M D D

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