

Contact details

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

Application for out-of-hospital management of a Prescribed Minimum Benefit condition

The latest version of the application form is available on www.lahealth.co.za. Alternatively members can phone 0860 103 933 and health professionals can phone 0860 44 55 66.

How to complete this application form

- 1. Please complete this form for cover of out-of-hospital management of a Prescribed Minimum Benefit (PMB) condition.
- 2. You need to complete section 1 of this form.
- 3. Your doctor must complete section 2 and 3 for acute and/or ongoing treatment for a Prescribed Minimum Benefit. Please include detailed documentation to support your application.
- Please fax this completed and signed form with any documentation to support this application to 011 539 2780 or email PMB_APP_FORMS@discovery.co.za
- 5. You will receive a letter informing you of our decision and the process you should follow.

1. Important patient info	ormation
Title Surname	
First name(s)	
Sex Identity number	Membership number
Telephone (H)	(w) (w)
Cellphone	Fax Fax
Email address	
Relationship to main member	
The outcome of this application	n can be communicated to me by email Yes No no r fax number Yes No No
	to provide LA Health Medical Scheme with my diagnosis and other relevant clinical information required to rev
	Ainimum Benefits. I understand that:
	d Minimum Benefit is subject to clinical entry criteria as determined by LA Health Medical Scheme.
2. Each case will be assessed o	
access to my medical record	ribed Minimum Benefits, I agree that my condition may be subject to periodic review and that this may include
	rescribed Minimum Benefit will only be effective from when LA Health Medical Scheme receives an application
form that is completed in fu	
5. The covered Prescribed Min	imum Benefit conditions and clinical entry criteria may change from time to time and I may need to send an
updated or new application	form, if LA Health Medical Scheme asks for this.
National and a signature	
Main member's signature	
Patient (unless a minor)	

Date of diagnosis	M M D D Treat	ment start	date Y Y	Y M M P P Treatment end	d date	M D D
_					duate	
.1 Application for acute and/or ongoing out-of		Consultation or		Motivation		Quantity
Condition	100 10 0000	procedure	couc	Wolfedien		Quantity
*Please clearly specify what is **The professional billing code						
Please attach any relevant sup						
2.2 Application for modifica						
2.2 Application for medicine Current medicine required (pleas	e provide supportive clini	cal results or	· information)			
Condition	ICD	-10 code	Madicina nam	o strangth and docago		Number of months
Condition	ICD	-10 code	wiedicine nam	e, strength and dosage		OI IIIOIILIIS
2.2 Application for redictors						
2.3 Application for radiology						Quantity
Condition		-10 code			per year	
2.4 Application for pathology						
Condition	ICD	-10 code	Description of	investigation		Quantity per year
	1					
3. Doctor's details (doc	ctor to complete)					
Name						
Practice number						
Fax						,
Email address						
Doctor's signature					Date Y Y Y M	M D D

4. Disclaimer

The doctor's fee for completion of this form will be reimbursed on code 0199, on submission of a separate claim. Payment of the claim is from the Medical Savings Account (if applicable to the member's benefit option), subject to LA Health Medical Scheme rules and availability of funds.

In line with legislative requirements, please ensure that when using code 0199, you submit the ICD-10 diagnosis code(s). As per industry standards, the appropriate ICD-10 code(s) to use for this purpose would be those reflective of the actual Prescribed Minimum Benefit condition(s) for which the form was completed. If multiple Prescribed Minimum Benefit conditions were applied for, then it would be appropriate to list all the relevant ICD-10 codes.