

External Medical Items Extender Benefit Application form

LA Comprehensive



Powered by Discovery

Contact details

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

Who are we

LA Health Medical Scheme (referred to as 'the Scheme'), registration number 1145, is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Scheme.

We update this form from time to time. The latest version of the application form is available on www.lahealth.co.za. Alternatively, members can call 0860 103 933 and healthcare professionals can call 0860 44 55 66 to request a form.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. Member must sign and complete section 1 of the application form.
3. Take the application form to your healthcare professional to complete section 2, section 5 and sign section 6 and section 7.
4. The application form must be accompanied by an assessment report from an Occupational Therapist or Physiotherapist and a quotation for the required medical external medical equipment.
5. Fax the completed application form to **011 539 2709**, email it to clinicalhelp@discovery.co.za, or post it to LA Health Medical Scheme, **PO Box 784262, Sandton 2146**.

1. Patient information (to be completed by the member)

Title	<input type="text"/>	Surname	<input type="text"/>
First name/s	<input type="text"/>		
Sex	M <input type="checkbox"/> F <input type="checkbox"/>	Identity number	<input type="text"/>
Membership number	<input type="text"/>		
Telephone (H)	<input type="text"/>	(W)	<input type="text"/>
Cellphone	<input type="text"/>	Fax	<input type="text"/>
Email	<input type="text"/>		
The outcome of this application can be communicated to me by email Yes <input type="checkbox"/> No <input type="checkbox"/>			

Patient's signature
(if patient is a minor, main member to sign)

Date

I acknowledge that I have read and understood the conditions under "Notes to member" (section 3).

2. Healthcare Professional's details

Name and surname	<input type="text"/>		
BHF practice number	<input type="text"/>		
Speciality	<input type="text"/>		
Telephone (W)	<input type="text"/>	Fax	<input type="text"/>
Email	<input type="text"/>		

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3. Notes to member

I give permission for my healthcare professional to provide LA Health Medical Scheme and Discovery Health (Pty) Ltd (as administrator) with my diagnosis and other relevant clinical information required to review my application for the External Medical Items Extender Benefit. I understand that:

- 3.1. Funding from the External Medical Items Extender Benefit is subject to meeting benefit entry requirements as determined by LA Health Medical Scheme.
- 3.2. The External Medical Items Extender Benefit only covers a defined list of external medical items as determined by LA Health Medical Scheme.
- 3.3. The External Medical Items Extender Benefit will only be applicable after the annual External Medical Items Benefit has been depleted the funded medical equipment will be paid up to 100% LA Health Rate.
- 3.4. By applying for the External Medical Items Extender Benefit, I agree that my condition may be subject to benefit parameters and guidelines as determined by the relevant professional body, disease management interventions and periodic review for clinical evidence and cost effectiveness and that this may require access to my medical records. I consent to LA Health Medical Scheme and Discovery Health (Pty) Ltd (as administrator) accessing these records/information as long as the records/information are always kept confidential and I understand that by not granting such access, this may lead to the withdrawal of the benefit.
- 3.5. Funding from the External Medical Items Extender Benefit will only be effective from when LA Health Medical Scheme approved the application.
- 3.6. I will need to send an updated or new application form, if I require additional medical equipment in the same benefit year.
- 3.7. I consent to LA Health Medical Scheme and LA Health (Pty) Ltd as the Administrator disclosing, from time to time, information supplied to LA Health Medical Scheme and LA Health (Pty) Ltd, as the Administrator, (including general, personal or medical information that is relevant to my application) to my healthcare provider, to administer my External Medical Items Extender Benefit. I agree that LA Health Medical Scheme and Discovery Health (Pty) Ltd, as the Administrator, may disclose this information at their discretion, but only as long as all the parties involved have agreed to keep the information always confidential.

4. Entry criteria for the External Medical Items Extender Benefit

- 4.1. If you are on the LA Comprehensive Option you may qualify for cover from the External Medical Items Extender Benefit if your annual External Medical Items (EMI) Benefit has been depleted.
- 4.2. All cases will be reviewed on individual merit and on case-by-case basis with severity of the condition and disability taken into consideration
- 4.3. The decisions made will not set a precedent, determine future benefits or affect LA Health Medical Scheme in any way.

List of possibly qualifying conditions:

Hemiplegia and Paraplegia
Quadriplegia (tetraplegia)
Cerebral Palsy
Motor neuron Disease
Parkinson's disease (and other movement disorders of the basal ganglia)
Multiple sclerosis (and other demyelinating CNS disorders)
Connective Tissue Disorder
Severe injuries resulting in severe disabilities
Spinal-muscular atrophy

Product categories funded through the External Medical Items Extender Benefit

Wheelchairs

- Standard wheelchairs
- Lightweight wheelchairs
- Motorized wheelchairs
- Specialised positioning wheelchairs

Wheelchair accessories e.g. cushions, Arm rest, Foot rests, Side panels etc.

Hoists

Standing frames

Scooters

5. Condition (to be completed by healthcare professional)

ICD-10	Diagnosis description	Date when condition was first diagnosed

6. Additional clinical information (to be completed by healthcare professional)

7. External Medical Item required (to be completed by healthcare professional)

NAPPI or SAOPA code	Description

***NB: Please attach quotation**

8. Notes to healthcare professional

- 8.1. 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 subject to Scheme rules and availability of funds and where the member is a valid and active member at the service date of the claim.
- 8.2. 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 chronic condition/s for which the form was completed. If funding for multiple chronic conditions were applied for, then it would be appropriate to list all the relevant ICD-10 codes.
- 8.3. The completed form may be sent by faxed to 011 539 7012 or email to clinicalhelp@discovery.co.za

Healthcare professional's signature

Date

D	D	M	M	Y	Y	Y	Y
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