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

LA Health
Powered by Discovery

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

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

Who we are

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.

How to complete this form

1. Please use one letter per block, complete with black ink and print clearly.
2. Fax the completed and signed form to 011 539 7000 or email it to **CIB_APP_FORMS@discovery.co.za**
3. To avoid administrative delays, please ensure this form 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

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

I give consent to LA Health Medical Scheme and Discovery Health (Pty) Ltd to use the above communication channel for all future communication.

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

2. Request for additional consultations and procedures (doctor to complete)

Your patient has automatic access to an annual treatment basket containing a limited number of consultations and procedures when approved for 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 required per year	Supporting information for the request

LHRACF001

3. Request for cover in full for non-formulary 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 additional information 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	Supporting information for the request

Previous medicine history

Medicine name and strength	Date treatment with this medicine was initiated	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

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

Doctor's signature

Date Y Y Y Y M M D D