External Medical Items Extender Benefit Application form

LA Comprehensive

LA Health
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 | Surname

First name/s

Sex M F | Identity number

Membership number

Telephone (H) | (W)

Cellphone | Fax

Email

The outcome of this application can be communicated to me by email Yes No

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

Date D D M M Y Y Y Y

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

2. Healthcare Professional's details

Name and surname

BHF practice number

Speciality

Telephone (W) | Fax

Email

3. Notes to member

I give permission for my healthcare professional to provide LA Health Medical Scheme with my diagnosis and other relevant clinical information required to review my application for Prescribed Minimum Benefits. I consent to LA Health Medical Scheme and Discovery Health (Pty) Ltd disclosing from time to time, information supplied to LA Health Medical Scheme and Discovery Health (Pty) Ltd (including general or medical information that is relevant to my application) to my healthcare provider, to administer my benefits. I agree that LA Health Medical Scheme may disclose this information at its discretion but only as long as all the parties involved have agreed to always keep the information confidential.
I understand that:

3.1. Funding from the Prescribed Minimum Benefit is subject to benefit entry criteria as determined by LA Health Medical Scheme.
3.2. Each case will be assessed on its own merit.
3.3. By registering for the Prescribed Minimum Benefits, I agree that my condition may be subject to disease management interventions and periodic review and this may include access to my medical records.
3.4. Treatment approved as a Prescribed Minimum Benefit will only be effective from when LA Health Medical Scheme receives an application form that is completed in full.
3.5. The covered Prescribed Minimum 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 or Discovery Health (Pty) Ltd asks for this.

Patient's Signature

(if patient is a minor, main member to sign)

Date D D M M Y Y Y Y

I acknowledge that I have read and understood the conditions under “Notes to member” (section 2).

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