

Application for additional services during an in-hospital admission for depression 2026

Contact details

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

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.

Who we are

LA Health Medical Scheme (referred to as 'the Scheme'), registration number 1145, is a not-for-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.

Purpose of the form

This form is to apply for funding for additional in-hospital services related to an approved depression admission in a psychiatric facility when the member's funding basket-of-care limits are depleted or services not included in the funding basket-of-care are required during the admission.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly. Alternatively, complete it digitally.
2. This form must be completed by the admitting or treating healthcare professional during which the admission period applies.
3. Please email this completed and signed form with any supporting documents to psychmanagement@discovery.co.za
4. You will receive an email informing you of our decision and the process you should follow for claims submission.

1. Important patient information

Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First name(s)	<input type="text"/>		
Authorisation number	<input type="text"/>	ID or passport number	<input type="text"/>
Membership number	<input type="text"/>	Cellphone	<input type="text"/>
Email	<input type="text"/>		

2. Application (Healthcare professional to complete)

Please note that all fields below are mandatory and the professional billing codes must be supplied for us to review the application.

ICD-10 code	Consultation or procedure code**	Consultation or procedure description	Quantity required	Motivation

All additional services requested are limited to the admission during which this form is submitted

3. Healthcare professional's details

Name	<input type="text"/>																
BHF practice number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Telephone	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email	<input type="text"/>																

Notes to healthcare professional

- 3.1. Please ensure that the relevant ICD-10 code(s) are used when you submit your claims to the Scheme to ensure payment from the correct benefit.
- 3.2. Please include the ICD-10 code(s) when referring your patient to the pathologists and/or radiologists. This will enable the pathologists and radiologists to include this information on their claims and allow us to pay claims correctly.
- 3.3. Please submit all the requested supporting documents with this application to prevent delays in the review process.

Healthcare professional's signature

Date