PRESCRIBED MINIMUM BENEFITS (PMBs) APPLICATION

Please note: Please do not use this form to apply for chronic medicine

COMPLETION OF THIS FORM

- Bestmed has appointed a Specialist Designated Service Provider (DSP) network for all Prescribed Minimum Benefits (PMBs).
- Members have the choice to voluntarily use non-DSP providers. However, non-DSP providers may charge higher fees or co-payments which would be for your own account.
- PMBs are subject to pre-authorisation and in the case of emergencies the application must be received within 48 hours.
- To avoid administrative delays, please ensure that all sections are completed in full and in the case of pre-authorisation a written quotation must accompany the fully completed PMB application form.
- The application form MUST be completed by the medical practitioner providing or prescribing the treatment/service and be signed by the member.
- Please ensure that all relevant diagnostic/medical reports are included with the completed application form.
- The completed form can be faxed to 012 472 6760 or sent via email to pmb@bestmed.co.za

SECTION A: PATIENT INFORMATION

Title | Initials

Surname

Member number

Date of birth (D D M M Y Y Y Y) | Gender (M F)

SECTION B: PMB CONDITION APPLIED FOR

ICD-10 code

Description:

SECTION C: ONGOING PMB SERVICES

MEDICINE APPLIED FOR:

Name & strength of medicine	Directions	Quantity per month	How long has the medicine been used	Number of repeats required	Start date of requested authorisation

CONSULTATION AND TREATMENT CODES APPLIED FOR:

NB: List all consultation, radiology, pathology and other treatment codes

Tariff code	Description	Quantity per month	Number of repeats required	Start date of requested authorisation

Patient Name

Surname

Member number

SECTION D: ACUTE OR EVENT SPECIFIC PMB SERVICES

Service date	Tariff code	Tariff charged	Service date	Tariff code	Tariff charged

Confirm billing practice / tariff structure of the practice applying for funding at cost.

Was the patient and / or member / family informed of the fees to be charged?

YES	NO

- If YES, please provide a copy of the signed document/consent.
- If NO, please motivate

SECTION E: MOTIVATION

Please attach copies of blood test results and / or any other relevant diagnostic reports.

SECTION F: DETAILS OF TREATING PROVIDER APPLYING FOR BENEFITS

Initials

Surname

Practice number

Speciality

Tel (W)

Fax

Signature of Treating Provider: _____ Date: _____

SECTION G: PATIENT CONSENT

I, (member) acknowledge that I am aware of the tariff structure of the practice, as well as the Bestmed funding guideline for approved services at the Bestmed rate. I choose to make use of this provider

I hereby give permission to the doctor or any other service porvider to state the diagnosis and mention any other information relating to my condition(s) on the form. I understand that this information will remain confidential at all times.

Signature of member: _____ Date: _____

SECTION H: CONSENT PROVISIONS BY APPLICANT

1. I hereby expressly make the following acknowledgements in respect of Bestmed's processing of my Personal Information and/or Special Personal Information and/or that of my dependants/child(ren)/spouse(s) ("collectively referred to as "Personal Information"), as defined in terms of the Protection of Personal Information Act, 4 of 2013 (POPIA):
   - 1.1 That I have read and understood the provisions of Bestmed's Data Protection and Privacy Policy, thereby fully appreciating the manner in which Bestmed may process my Personal Information and for which purpose(s) Bestmed may process such Personal Information.
   - 1.2 That through submitting this application, I may be providing Bestmed with the Personal Information of my spouse(s), children and/or other dependant third parties.
   - 1.3 That by engaging with Bestmed through any physical and/or electronic means, Bestmed will in effect be processing the Personal Information provided by me from time to time.
   - 1.4 That Bestmed may from time to time, depending on the circumstances, collect my Personal Information from another source other than myself.
   - 1.5 That I fully appreciate that Bestmed places a high premium on my privacy and/or that of my dependants, spouse(s) and/or children.
   - 1.6 That I have read and understood the undertakings made by Bestmed in its Data Protection and Privacy Policy to the effect that it will ensure that any and all of my Personal Information and/or that of my dependants/child(ren)/spouse(s) shall be processed with a reasonable standard of care as may be expected from Bestmed.
   - 1.7 That I fully appreciate that Bestmed will only process my Personal Information and/or that of my dependants/child(ren)/spouse(s) in a manner consistent with the provisions of its Data Protection and Privacy Policy, as well as for the purpose(s) set forth therein.
   - 1.8 That, in accordance with the provisions of Section 18 of POPIA, I have been provided with adequate notification of the processing of my Personal Information by Bestmed, the scope and purpose(s) for such processing, as well as my rights to object to such processing should I elect to do so.
   - 1.9 That I acknowledge that the processing of my Personal Information is a mandatory requirement for the existence of a valid medical aid.

2. In light of the above acknowledgements, and in accordance with the requirements set forth in Section 11 of POPIA, I hereby provide my specific and informed consent to Bestmed for the processing of my Personal Information and/or that of my dependants/child(ren)/spouse(s), for any purpose(s) legitimately connected or related to my application for membership, which purpose(s) may include, but not be limited to the following:
   - 2.1 To provide or manage any information, products and/or services requested by me pursuant to my application for membership.

2.2 To establish my needs, requirements and preferences in relation to the products and/or services provided by the Bestmed.

2.3 To facilitate the delivery of products and/or services to me as a member of Bestmed.

2.4 To administer my claims and premiums.

2.5 To activate my medical aid and/or prescribed benefits.

2.6 To allocate a unique identifier to me for the purpose of securely storing, retaining, and recalling my Personal Information from time to time, including after my membership is terminated.

2.7 For general administration purposes pertaining to my membership.

2.8 For legal and/or contractual purposes and to enable Bestmed to comply with its contractual obligations towards me.

2.9 To transact with suppliers and business partners, including healthcare service providers, managed facilities, network hospitals, pharmacies and relevant regulatory authorities to facilitate the delivery of products and/or services to me.

2.10 To provide me with health and wellness information throughout the subsistence of my membership.

2.11 To transact with third parties and transfer my Personal Information to such third parties for the purpose of enabling Bestmed to fulfil its contractual obligations towards me.

2.12 To analyse my Personal Information collected for research and statistical purposes.

2.13 To transfer my Personal Information across the borders of South Africa to other jurisdictions should it be required in the legitimate pursuit of Bestmed's business requirements.

2.14 To carry out analysis and profiling of my membership profile.

3. In as far as I provide Bestmed with the Personal Information of any third party, including my spouse(s), children or other dependants, I hereby warrant that I have acquired the consent of such third party to do so and in the event of that individual being a child, I do so in my capacity as a "competent person" in respect of such Personal Information, as contemplated in terms of the provisions of POPIA.

   Accordingly, I hereby indemnify and hold Bestmed harmless against any claims of whatever nature that may arise as a result of the processing of any Personal Information as provided by myself, for purposes of my membership with Bestmed.

4. Bestmed may identify other products and services which might be of interest to me, as well as to inform me of such products and/or services.

Yes	No

Signature of applicant