# 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.
- 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 |
|---|---|---|---|---|---|
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**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 |
|---|---|---|---|---|
| | | | | |
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| | | | | |
| | | | | |
| | | | | |
| | | | | |

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 |
|---|---|---|---|---|---|
| | | | | | |
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**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.

Is the treatment in accordance with treatment as practised in the state sector?

If so, at which state institution is this practised?

## SECTION F: DETAILS OF DOCTOR APPLYING FOR BENEFITS

Initials

Surname

Practice number

Speciality

Tel (W)

Fax

Signature of doctor: Date:

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.

Signature of member: Date: