BMW Employees Medical Aid Society

Administered by Discovery Health

Contact details
Tel: 0860 002 107 • PO Box 652509, Benmore 2010 • www.bemas.co.za

Request for additional cover for out-of-hospital Prescribed Minimum Benefit conditions 2024

Who we are

The BMW Employees Medical Aid Society (referred to as 'Society'), registration number 1526, 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 Society.

The latest version of the application form is available on www.bemas.co.za. Alternatively, members can call 0860 002 107 and healthcare professionals can call 0860 44 55 66 for us to send the latest form.

About this form

This form should be completed when a member needs out-of-hospital treatment that falls outside of the basic level of care provided for in the Prescribed Minimum Benefits.
Please only complete this form if we have already reviewed a request for funding for your condition as a Prescribed Minimum Benefit. Otherwise please complete the "Application for out-of-hospital management of a Prescribed Minimum Benefit condition" form.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. You (the member) must complete sections 1 and 2 of this form.
3. Your Doctor must complete sections 3 and 4 and include detailed documents to support this application for treatment of a Prescribed Minimum Benefit.
4. Please email this completed and signed form with any supporting documents to **PMB_APP_FORMS@bemas.co.za** or fax it to **011 539 2780**.
5. You will receive a letter informing you of our decision and the process you should follow for claims submission.
6. You may call us if you would like to lodge a formal dispute to a declined decision.

1. Patient details (member to complete)

First name(s)

Surname

Date of birth (D D M M Y Y Y Y) ID or passport number

Membership number

Telephone (H) Telephone (W)

Cellphone Fax

Email

The outcome of this application can be communicated to me via Email ☐ Fax ☐

2. Notes to member

I give permission for my doctor to provide BMW Employees Medical Aid Society and the administrator with my diagnosis and other relevant clinical information required to review my application. I agree to my information being used to develop registries. This means that you give permission for us to collect and record information about your condition and treatment. This data will be analysed, evaluated and used to measure clinical outcomes and make informed funding decisions.

I understand that:

2.1. Funding from Prescribed Minimum Benefit is subject to meeting clinical entry criteria requirements as determined by BMW Employees Medical Aid Society and the administrator.
2.2. The Prescribed Minimum Benefit provides cover for disease-modifying therapy only, which means that not all medicines for a listed condition are automatically covered by Prescribed Minimum Benefits.
2.3. By registering for Prescribed Minimum Benefits, I agree that my condition may be subject to disease management interventions and periodic review and that this may include access to my medical records.

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Please note that this form expires on 31/03/2025. The latest version of the application form is available on www.bemas.co.za. Alternatively members can phone 0860 002 107 and health professionals can phone 0860 44 55 66.

2.4. Funding for treatment from Prescribed Minimum Benefit will only be effective from when BMW Employees Medical Aid Society or the administrator receives an application form that is completed in full.

2.5. An application form needs to be completed when applying for a new PMB condition.

2.6. If you are approved on the benefit, you need to let us know when your treating doctor changes your treatment plan so that we can update your Prescribed Minimum Benefit authorisation/s. You can do this by emailing the new prescription to us or asking your doctor or pharmacist to do this for you.

2.7. To make sure that we pay your claims from the correct benefit, we need the claims from your doctors to be submitted with the relevant ICD-10 diagnosis code(s). Please ask your doctor to include your ICD-10 diagnosis code(s) on the claims they submit and on the form that they complete when they refer you to the pathologists and/or radiologists for tests. This will enable the pathologists and radiologists to include the relevant ICD-10 diagnosis code(s) on the claims they submit, ensuring that we pay your claims from the correct benefit.

Consent for processing my personal information

I give the Society and the administrator consent to have access to and process all information (including general, personal, medical or clinical information) that is relevant to this application. I understand that this information will be used for the purposes of applying for and assessing my funding request for Prescribed Minimum Benefits. I consent to the Society and the administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical information) to my doctor and to relevant third parties, to administer the Prescribed Minimum Benefits as well as undertake managed care interventions related to the PMB condition.

Withdrawing consent for your general, personal, medical or clinical information to be accessed or shared with relevant third parties, means that you will no longer have access to funding from the applicable disease management benefits. Claims which would usually be funded from the disease management benefits will, once consent is withdrawn, be funded from other available benefits according to the rules of your plan. Should you wish to withdraw consent, then please call **0860 002 107**.

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).

3. Application (Doctor to complete)

3.1. Application for out-of-hospital treatment*

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

* Please clearly specify what is required, for example consultations, pathology, radiology and/or procedure.
** The professional billing codes must be supplied for us to review the application.

Please attach any relevant supporting documentation, for example pathology tests.

When applying for mental health conditions over and above the sessions provided for, please submit a DSM V form including the GAF (Global Assessment of Functioning) score.

3.2. Application for medicine

Current medicine required (please provide supportive clinical results or information, where necessary)

Condition	ICD-10 code	Medicine name, strength and dosage	How long has the patient used this medicine?	
			Years	Months

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3.3. Application for radiology

Condition	ICD-10 code	Procedure code	Procedure description	Quantity required

3.4. Application for pathology

Condition	ICD-10 code	Procedure code	Procedure description	Quantity required

4. Doctor's details

Name and surname

BHF practice number

Speciality

Telephone

Fax

Email

Outcome of this application must be sent to me via Email Fax

Notes to Doctor

4.1. Please ensure that the relevant ICD-10 diagnosis code(s) are used when you submit your claims to the Society to ensure payment from the correct benefit.

4.2. Please include the ICD-10 diagnosis 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 comply with legislation by paying Prescribed Minimum Benefits (PMB) claims correctly.

4.3. We will approve funding for generic medicine, where available, unless you have indicated otherwise.

4.4. Please submit all the requested supporting documents with this application to prevent delays in the review process.

4.5. Should you make changes to your patient's treatment plan, you need to let us know so that we can update their PMB authorisation/s. You can do this by emailing the new prescription to us. If you or your patient do not let us know about changes to the treatment plan, we may not pay claims from the correct benefit.

Doctor’s signature

Date D D M M Y Y Y Y