BMW Employees Medical Aid Society

Administered by Discovery Health

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

# Application for out-of-hospital management of a Prescribed Minimum Benefit condition 2024

**Please complete this form for cover of out-of-hospital management of a Prescribed Minimum Benefit (PMB) condition.**

**Who we are**

The BMW Employees Medical Aid Society (referred to as 'BEMAS'), registration number 1526, is a non-profit organisation, registered with the Council for Medical Society.

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.

**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 section 1 of this form.
3. Your Healthcare professional must complete sections 2 and 3 and include detailed documents to support this application for treatment of a Prescribed Minimum Benefit.
4. Please fax this completed and signed form with any supporting documents to **011 539 2780** or email it to **PMB_APP_FORMS@bemas.co.za**.
5. You will receive a letter informing you of our decision and the process you should follow.

## 1. Important patient information

Title

Surname

First name(s)

ID or passport number

Gender M F

Membership number

Telephone (H)

Telephone (W)

Cellphone

Fax

Email address

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

**Member's acceptance and permission**

I give permission for my healthcare provider 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:

1.1. Funding from Prescribed Minimum Benefit is subject to meeting benefit entry criteria as determined by BMW Employees Medical Aid Society and the administrator.

1.2. 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.

1.3. 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.

1.4. 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.

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

1.6. 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.

1.7. To make sure that we pay your claims from the correct benefit, we need the claims from your healthcare providers 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 healthcare provider 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 signature

**if patient is a minor, main member to sign**

Date D D M M Y Y Y Y

## 2. Application (doctor to complete)

Date of diagnosis D D M M Y Y Y Y

### 2.1. Application for out-of-hospital treatment*

| Condition | ICD-10 Code | Consultation or procedure code** | Consultation or procedure description | Quantity required |
|---|---|---|---|---|
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*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 documents, for example pathology tests.

**Applications for psychotherapy:**

- If the application is for psychotherapy treatment for members younger than 13 years of age, the scheme will require the latest Diagnostic and Statistical Manual of Mental Disorders (DSM V) form including the Global Assessment of Functioning (GAF) score.
  Date of 1st psychotherapy session D D M M Y Y Y Y

### 2.2. 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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| | | | | |

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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.

### 2.3. Application for radiology

| Condition | ICD-10 code | Procedure code | Procedure description | Quantity required |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

### 2.4. Application for pathology

| Condition | ICD-10 code | Procedure code | Procedure description | Quantity required |
|---|---|---|---|---|
| | | | | |
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| | | | | |

## 3. Doctor's details

Name

BHF practice number

Specialty

Contact number

Fax

Email address

**Notes to doctor**

3.1. 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.

3.2. 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.

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

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

3.5. 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