



APPLICATION FORM

PRESCRIBED MINIMUM BENEFIT (PMB) CARE PLAN

TO BE COMPLETED BY APPLICANT

MEMBER DETAILS:

MEMBERSHIP NUMBER

SURNAME

TITLE INITIALS

E-MAIL ADDRESS

PATIENT DETAILS:

NAME AND SURNAME

TITLE ID NUMBER OR DATE OF BIRTH

ADDRESS

E-MAIL ADDRESS

TELEPHONE (H) (W)
 (CELL)

I authorise my medical practitioner to furnish and/or disclose to the PMB Programme any fact relating to this application as well as any additional information that may be required from time to time.

MEMBER'S SIGNATURE _____ DATE

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

DOCTOR DETAILS:

SURNAME INITIALS

PRACTICE NUMBER SPECIALITY

TELEPHONE FAX

CELLPHONE

POSTAL ADDRESS CODE

E-MAIL ADDRESS

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER (CONTINUED)

ASSOCIATED SPECIALIST DETAILS:

NAME

PRACTICE NUMBER

 SPECIALITY

CLINICAL EXAMINATION:

MALE/FEMALE M F WEIGHT

 kg HEIGHT

 cm BLOOD PRESSURE

 /

SMOKING: NEVER EX-SMOKER <10 PER DAY >10 PER DAY

EXERCISE: NEVER <1 HOUR PER WEEK 1-3 HOURS PER WEEK >3 HOURS PER WEEK

ALLERGIES: PENICILLIN ASPIRIN SULPHONAMIDES

 OTHER

PLEASE NOTE THAT CLINICAL INFORMATION IS MANDATED PRIOR TO THE AUTHORISATION OF A PMB CARE PLAN AND WHEN ADDITIONAL SERVICES ARE REQUIRED.

AUTHORISED CHRONIC MEDICATION IN USE (Please use block letters)

ICD-10 Code(s)	Diagnosis	Name of medication	Strength (e.g. 50mg)	Directions (e.g. 2tds)

PRESCRIBED MINIMUM BENEFITS

Please indicate which condition(s) your patient has by placing an "X" next to the applicable condition.

Addison's Disease	Crohn's Disease	Hypertension
Asthma	Diabetes Insipidus	Hypothyroidism
Bipolar Mood Disorder	Diabetes Mellitus Type 1	Multiple Sclerosis
Bronchiectasis	Diabetes Mellitus Type 2	Parkinson's Disease
Cardiac Failure	Dysrhythmias	Rheumatoid Arthritis
Cardiomyopathy Disease	Epilepsy	Schizophrenia
Chronic Obstructive Pulmonary Disorder	Glaucoma	Systemic Lupus Erythematosus
Chronic Renal Disease	Haemophilia	Ulcerative Colitis
Coronary Artery Disease	Hyperlipidaemia	

