



# 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	

**Please take note of the following:**

- Your treating doctor is required to complete the PMB Application Form annually.
- The information contained in this application form is used to draw up your PMB Care Plan.
- Your PMB Care Plan benefits will be paid from the PMB benefit once your Annual Medical Limit benefit has been depleted.
- Treatment and care is strictly for the 26 PMB Chronic Disease List (CDL) conditions. Please ensure that your treating doctor includes the correct ICD-10 codes to ensure that your claims are paid from the appropriate benefit.
- If you or your beneficiary is authorised for a PMB Care Plan during the course of the year; the services outlined in the Care Plan will be granted on a prorated basis.

I hereby acknowledge that the scheme has appointed Qualsa Healthcare (Pty) Ltd as the administrator of the programme and that any prescribed medical treatment shall be the sole responsibility of my medical practitioner.

I understand that the information provided on this form shall be treated as confidential and will not be used or disclosed except for the purpose for which it has been obtained.

Whilst Qualsa undertakes to take all reasonable precautions to uphold the confidentiality of information disclosed to it, I am aware that my medical scheme and practitioner (where necessary) shall also gain access to the same information. I shall therefore not hold Qualsa liable for any claims by me or my dependants arising from any unauthorised disclosure of my personal information to other parties.

I hereby certify that the information provided is true and correct.

_____ MEMBER'S SIGNATURE	_____ PRESCRIBING DOCTOR'S SIGNATURE	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px; text-align: center;">D</td><td style="width: 20px; height: 20px; text-align: center;">D</td><td style="width: 20px; height: 20px; text-align: center;">M</td><td style="width: 20px; height: 20px; text-align: center;">M</td><td style="width: 20px; height: 20px; text-align: center;">Y</td><td style="width: 20px; height: 20px; text-align: center;">Y</td><td style="width: 20px; height: 20px; text-align: center;">Y</td><td style="width: 20px; height: 20px; text-align: center;">Y</td></tr></table> DATE	D	D	M	M	Y	Y	Y	Y																															
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**RETURN ADDRESS:** DISEASE RISK MANAGEMENT PROGRAMME  
61 ST GEORGE'S MALL, CAPE TOWN 8001 OR PO BOX 15079, VLAEBERG 8018  
**ENQUIRIES:** TEL 021 480 4460 **EMAIL:** wooltrupmb@mhg.co.za