Reg. No.: 1464
7 Lutman Street, Richmond Hill, Port Elizabeth, 6001
P.O. Box 1672, Port Elizabeth, 6000
Customer Care\Hospital Authorisations: 0860080888
Email: info@suremedhealth.co.za
www.suremedhealth.co.za

PRESCRIBED MINIMUM BENEFITS (PMB) APPLICATION

SECTION A - IMPORTANT INFORMATION

1. An application must be completed per beneficiary applying for funding.
2. You will receive communication regarding the outcome of this application.
3. The Scheme has a basket of diagnostic tests and consultations for each Chronic Disease List (CDL) Prescribed Minimum Benefit (PMB) condition.
4. Please attach the relevant claims to this form or alternatively complete the section for previously processed claims below.
5. Send completed forms to info@suremedhealth.co.za or mail PO Box 1672, Port Elizabeth, 6000

SECTION B - RULES APPLICABLE TO THE PRESCRIBED MINIMUM BENEFITS

1. The Scheme has selected the State as well as certain private service providers as the Designated Service Provider (DSP).
2. Should members voluntarily obtain a service from a provider other than the DSP, we will cover their claims as per the Scheme rules, i.e. subject to benefit limits and co-payments if applicable.
3. A claim will also be considered if a non-DSP has been used involuntarily.
4. If you require any further information or clarity regarding the funding and management of PMB's please contact Suremed at 086 008 0888 or the Suremed website.

SECTION C - PATIENT INFORMATION (to be completed by member)

Scheme ____ Option ____

Member Number ____ Title ____ Date of Birth Y Y M M D D

Surname ____ First Names ____

ID Number ____ Telephone number ____

Fax number (Confidential) ____ Mobile ____

Email address (Confidential) ____

Postal Address ____

____ Code ____

SECTION D - DETAILS OF THE MEDICAL CONDITION (to be completed by doctor)

Please complete the table below regarding the PMB claim category type

Condition (ICD10 in brackets)	Tariff code	Quantity	Motivation

Attach relevant supporting documention, e.g. pathology results. If the application is for psychotherapy treatment of Major Depressive Disorder, the scheme will require the latest DSM V form including the GAF (Global Assessment of Functioning) score.

Doctor's Name ____ Practice Number ____

Contact Number ____ Doctor's Signature ____

Certified by: SABS ISO 9001

Administered by: momentum TYB

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A member of: Momentum Metropolitan

Surname | | | | | | | | | | Initials | | Membership Number | | | | | | | | | | | |

SECTION E - CLAIM DETAIL

1. If we have processed the claim previously or if the claim has been sent directly to us, and you would now like it reimbursed from the Prescribed Minimum Benefits, please complete this section below.
2. You can obtain all the information about your claims from your claims statement.

Service Provider	Practice Number	Service Date	Treatment	Claim or Reference
		Y Y Y Y M M D D		
		Y Y Y Y M M D D		
		Y Y Y Y M M D D		
		Y Y Y Y M M D D		
		Y Y Y Y M M D D		
		Y Y Y Y M M D D		
		Y Y Y Y M M D D		
		Y Y Y Y M M D D		

SECTION F - PATIENT DECLARATION

By signing below, I hereby give permission for, acknowledge and/or agree to the following:

- My (or my minor dependant's) doctor may provide clinical information regarding my/minor's condition to Suremed Health;
- Any information concerning this application will remain confidential at all times;
- It may be a pre-condition to the approval of the Chronic Medication Benefit that I register and comply with the requirements of a Disease Management Programme and that non-compliance may lead to the withdrawal of this benefit;
- My (or my minor dependant's) doctor retains the responsibility for my (or my minor dependant's) condition, based on the understanding that I (or my minor dependant) also has a responsibility towards my (or my minor dependant's) own health concerns, irrespective of the outcome of this application.
- This funding authorisation is at all times subject to the Scheme rules even if a member's circumstances change after the authorisation is provided. This authorisation is not a guarantee of payment.
- This funding authorisation is based on the most appropriate clinical criteria in terms of the Scheme rules and protocols. All treatment decisions remain the responsibility of the of the beneficiary's health care provider irrespective of the funding decision made in terms of the Scheme rules, clinical criteria and protocols.
- The Administrator shall not accept responsibility for any act, errors or omissions, loss, damage or consequences of individual responses to the treatment authorised or not authorised for funding by the Scheme.

Patient Signature ______________________________ Y Y Y Y M M D D
(or member if patient is a minor)

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