APPLICATION FOR PRESCRIBED MINIMUM BENEFITS

Selfmed
MEDICAL SCHEME

- Use only black ink.
- Use block capital letters to fill in the spaces.
- Use only one character per block.
- Leave one block empty between words.
- Where necessary, mark block clearly with a X.

Tel: 0860 787 372
Fax: 0860 288 363
Selfmed Medical Scheme
PO Box 5543
Tygervalley 7536
Reg. No: 1446

Member number:

A MEMBER'S DETAILS

Surname

Initials

Full names

Title

Selfmed Option name

Membership number

B PATIENT'S DETAILS

Surname

Initials

Name

Title

ID number

Date of birth D D M M Y Y Y Y

Beneficiary code

Physical address

Postal code

Postal address

Postal code

Telephone (h)

Telephone (w)

Cellphone number

Fax number

E-mail address

Preferred method of communication

☐ Telephone ☐ E-mail ☐ SMS ☐ Ordinary mail

C PLEASE SPECIFY THE CONDITION FOR WHICH YOU ARE REQUESTING ADDITIONAL BENEFITS

Condition

ICD – 10 Code

D DETAILS OF THE MEDICAL PRACTITIONER

Practice number

Surname

Initials

Full names

Title

Street address

Postal code

Postal address

Postal code

Telephone(h)

Telephone (w)

Cellphone number

Fax number

Email address

E MOTIVATION (PLEASE PROVIDE A BRIEF OUTLINE OF YOUR CONDITION)

When were you diagnosed with this condition? D D M M Y Y Y Y

What treatment (medication, etc) are you currently taking? When

Was the last time you visited your GP for this condition? D D M M Y Y Y Y

Do you smoke? Yes No Indicate your level of physical activity

By completing this application form, you are applying for benefits to manage your PMB condition in accordance with legislation and the Selfmed scheme rules. This is, however, not an application for chronic medicine benefits.
To obtain chronic medicine authorisation, please request your treating physician to phone Selfmed on 0860 247 288.

I/we understand that all personal and clinical information supplied will be kept confidential. The information will be used to determine the patient's eligibility for additional benefits (and the reimbursement thereof) in order to manage their condition.

I/we hereby authorize any medical practitioner and/or medical facility in possession of any medical information with regards to my medical condition to provide the managed healthcare provider of Selfmed Medical Scheme from time to time, with such information as they may require.

Signature: Member

Signature: Patient (not required if patient is a minor)

Date D D M M Y Y Y Y