

# APPLICATION FORM - OUT OF HOSPITAL MANAGEMENT OF PMB's

1. This form is only for registration of out of hospital prescribed minimum benefits (PMB) conditions.  
(Do not use this form for conditions listed under the CDL or Additional Chronic Conditions).
2. This form is only for registration of an initial or newly diagnosed PMB condition. For any changes to medication for an existing approval, please fax the prescription with the relevant ICD 10 codes to 011 707 8866.
3. One form must be completed per patient.
4. Once completed, please email, fax or post to:  
Email: pmbdtp@camaf.co.za  
Fax no: 011 707 8866  
Post: CAMAF, P.O. Box 2964, Randburg, 2125
5. Forms not completed in full will not be processed.
6. Section 1 of application form must be completed by the member.
7. Sections 2 and 3 must be completed by your doctor.
8. Approval of any PMB condition and medicine is subject to clinical entry criteria and drug utilisation reviews.
9. Reference Pricing applies to all PMB medicine.
10. CAMAF has appointed a Pharmacy Network for dispensing of PMB medicine. Should you choose not to purchase your PMB medicine from a Network Pharmacy a co-payment will apply. Please refer to CAMAF's website for a list of pharmacies in the network.
11. If you are on Alliance Network, Double Network or Network Choice option, please note the following:
  - Your treating GP must be your nominated network GP.
  - Your repeat prescription for chronic medication will only be payable if it is from your nominated GP or a specialist.
  - If you change your nominated GP during the year, you must remember to get a new script from your new nominated GP for your chronic medication.
12. For any queries relating to this benefit please email us at pmbdtp@camaf.co.za
13. Attach copies of any reports to support the diagnosis of the PMB condition, where applicable.

## 1. PATIENT INFORMATION Please tick (✓) applicable box

Surname	<input type="text"/>	Initials	<input type="text"/>
Full Name(s)	<input type="text"/>		
Membership No.:	<input type="text"/>		
RSA Identity No./Passport No.	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	Gender (M=Male; F=Female) <input type="checkbox"/>
Date of Birth	<input type="text"/>		
Telephone:			
Home Code	<input type="text"/>	No. <input type="text"/>	Cell No. <input type="text"/>
Work Code	<input type="text"/>	No. <input type="text"/>	Fax Code <input type="text"/> No. <input type="text"/>
E-mail Address	<input type="text"/>		
We can contact you for feedback on your application via email <input type="checkbox"/> or fax <input type="checkbox"/>			
I understand that my application will not be processed if the information on this form is incomplete or the relevant diagnostic results are not provided to CAMAF. I give permission to my doctor to provide CAMAF with my diagnosis and other relevant clinical information to review my PMB application.			
_____ Principal Member Signature		_____ Patient/Guardian Signature	
		_____ Date	



CAMAF Membership No.:

## 2. PMB APPLICATION (DOCTOR TO COMPLETE)

### 2.1 PMB Condition Applied for:

ICD 10 Code	PMB Code	PMB Description	Date of Diagnosis	Ongoing / Acute Medical Management*

\*Please confirm whether this condition is for acute or ongoing medical management.

### 2.2 Medicine Application

ICD 10 Code	Medicine name and Strength	Dosage	Quantity per month	Number of Months

### 2.3 Procedures Application

List all consultations, pathology, radiology, procedures and any other treatment required out of hospital

ICD 10 Code	Tariff Code	Tariff Description	Quantity	Start Date

## 3. DOCTOR DETAILS

Name

BHF Practice Number  Speciality \_\_\_\_\_

Telephone: Work

Fax Number

Doctor's Signature \_\_\_\_\_ Date

- Please ensure all relevant reports and / or tests are included with this application form.
- For completion of this application form use claim code 0199. Please remember to use the relevant diagnosis ICD 10 code with the claim.
- This form only needs to be completed when applying for a new PMB condition. For any changes to the patient's medicine for approved conditions please call 0800 200 300 or please fax the prescription with the diagnostic ICD 10 code to 011 707 8622.

