



PMB PROGRAMME APPLICATION FORM

Email: PMBApplcations@medshield.co.za

Please complete in black ink. Print clearly using capital letters. Only one character per block. Leave one block between words.
Mark with an X where necessary. All sections must be completed.

Membership Number:

SECTION A

MEMBERSHIP DETAILS

Principal Member Surname:

Principal Member First Names:

Principal Member ID No:

Gender: (Mark with an X)

M	F
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PATIENT DETAILS

Patient Surname:

Patient First Name:

Patient ID/Passport Number:

Date of Birth:

Postal Address:

Postal Code:

Email Address:

Telephone Number (W):

Cell Number:

Fax Number:

Gender: (Mark with an X)

M	F
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Dependant Code:

I, _____ (patient's name and surname) the undersigned, declare that:

- a) I understand that all personal clinical information supplied to the PMB programme will be used to determine access to specific benefits for PMB conditions.
- b) The programme's Medical staff will review this information in order to make recommendations regarding the provision of these benefits. My/my dependant/s healthcare provider, however, retains responsibility for my/my dependant/s care, irrespective of the benefits so authorised.
- c) I/we therefore authorise any healthcare provider, hospital, clinic, laboratory and/or medical facility in possession of any medical information. regarding myself (the applicant) or any dependant (including new born baby), to provide the PMB programme with information that it may require.
- d) I warrant that the information in this application form is correct. I acknowledge that I will be responsible for any co-payments as per Scheme Rules or payment for any medication and/or investigations not authorised by the PMB team.
- e) I understand and agree that medical information relevant to my current state of health can be used for the purpose of scientific, epidemiological and/or financial analysis without disclosure of my identity.
- f) I acknowledge that benefits authorised by the PMB programme are subject to Managed Care guidelines.
- g) I am aware that more information on the PMBs can be obtained from the Scheme and the Council for Medical Schemes (CMS).

Principal Member Signature: _____

Date:

SECTION B

TREATING HEALTHCARE PROVIDER DETAILS

Title: Initials:

Provider Surname:

Practice Number:

Postal Address:

Postal Code:

Physical Address:

Email Address:

Telephone Number (W):

Cell Number:

Fax Number:

SECTION C

TREATMENT (to be completed by the Healthcare Provider)

CLINICAL HISTORY

Please specify the condition for which you are requesting access to PMB benefits.

Condition	ICD-10 Code	Is the patient currently on medication?		When was diagnosis first made?
		Y	N	YEAR
		Y	N	YEAR
		Y	N	YEAR
		Y	N	YEAR

TREATMENT PLAN

Condition	Procedure or consultation NHRPL tariff code	Number of procedures or consultations required per year	Number of procedures or consultations required per year

