

Applying for cover for Lymphoedema 2026



Contact us

Tel: 0860 100 078 • PO Box 652509, Benmore 2010 • www.medipos.co.za

Who we are

MEDIPOS Medical Scheme (referred to as 'the Scheme'), registration 1548, is a non-profit organisation, registered with the Council for Medical Schemes. Discovery Health (Pty) Ltd (referred to as 'the Administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). Discovery Health takes care of the administration of your membership for the Scheme.

What you must do

- Fill in the form in black ink and print clearly. Alternatively, complete it electronically by typing in the fields below.
- Ensure the form and photographs are sent to us by email at oncology@medipos.co.za.
- Only applications received from healthcare providers will be accepted.
- You will receive a letter informing you of our decision and what to do next for approved requests. If you have any questions, you can contact us on **0860 100 078**.

1. Patient's details

Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First name(s) (as per identity document)	<input type="text"/>		
ID or passport number	<input type="text"/>	Membership number	<input type="text"/>
Cellphone	<input type="text"/>	<input type="text"/>	
Email	<input type="text"/>		

2. Lymph node status

Regional node dissection	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, state region:	<input type="text"/>
Sentinel lymph node biopsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Chemotherapy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Still to be decided	<input type="checkbox"/>
If yes	Adjuvant <input type="checkbox"/>	Neoadjuvant <input type="checkbox"/>	Oral	<input type="checkbox"/>
Radiation therapy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Still to be decided	<input type="checkbox"/>
If yes, state area			Still due for radiology	<input type="checkbox"/>

3. Existing medical conditions and co-morbidities

<input type="text"/>

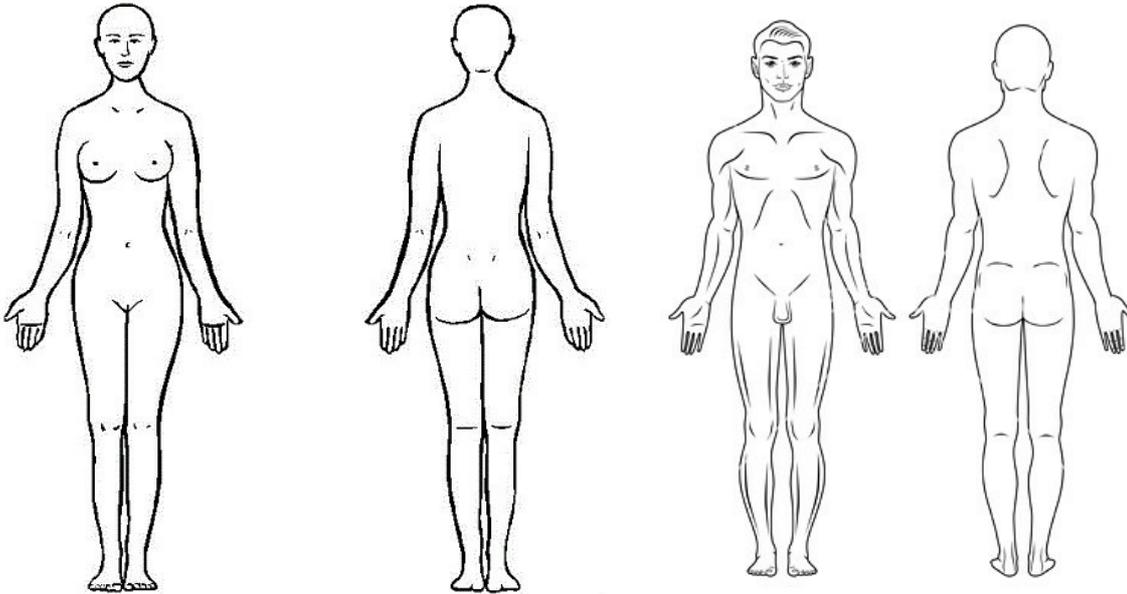
4. Any factors that may complicate, influence or affect prognosis for lymphoedema treatment

(If more space is required, please provide on a separate letter attached to this motivation)

5. Previous lymphoedema treatment (include nature of treatment and duration)

6. Limb circumference measurements (in cm)

Upper limb:	Right	Left	Lower limb:	Right	Left
Index finger			Big toe		
Thumb			Metatarsophalangeal		
Metacarpophalangeal			Mid-foot		
Distal wrist crease			Ankle		
cm			cm		
cm			cm		
cm			cm		
cm			cm		
cm			cm		
Elbow			Knee		
cm			cm		
cm			cm		
cm			cm		
cm			cm		
cm			cm		
Total limb vol:			Total limb vol:		
Excess total limb vol (%):			Excess total limb vol (%):		



7. Proposed treatment

Lymphoedema therapist	<input type="text"/>																
BHF practice number	<input type="text"/>	Staging	<input type="text"/>														
Date of staging	<input type="text"/>	Treatment start date	<input type="text"/>														

Initial consultation

Requested code	Cost
Total cost	

Treatment

Requested code	Cost	Frequency	Motivation
Total cost			

Garments and bandages

NAPPI code	Cost	Quantity	Description
Total cost			

Total cost of proposed treatment	<input type="text"/>
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Signature of healthcare provider	<input type="text"/>	Date	<input type="text"/>						
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