

# Request for additional cover for Chronic Conditions registered on the Chronic Medicine Benefit 2026



**Contact us**

Tel: 0860 100 078 • PO Box 652509, Benmore 2010 • [www.medipos.co.za](http://www.medipos.co.za)

**Who we are**

MEDIPOS Medical Scheme, registration number 1548, is a not-for-profit organisation registered with the Council for Medical Schemes, and is the medical scheme that you are a member of.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, is a separate company and an authorised financial services provider and is the Administrator and managed care organisation for MEDIPOS Medical Scheme and takes care of the administration of your membership.

**Purpose of the form**

This application form is to apply for additional cover for Prescribed Minimum Benefit (PMB) chronic conditions registered on the Chronic Medicine Benefit and is only valid for 2026.

**What you must do**

- Complete the form in black ink and print clearly or complete it digitally.
- All relevant sections must be physically signed by the healthcare provider and cannot be signed digitally. The healthcare provider must sign and date any changes.
- Email the completed and signed form to [CIB.app.forms@medipos.co.za](mailto:CIB.app.forms@medipos.co.za).
- To avoid administrative delays, please ensure this form is completed in full by you and your provider.

**1. About the patient (main member to complete if patient is a minor)**

Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First name(s)	<input type="text"/>		
ID or passport number	<input type="text"/>	Membership number	<input type="text"/>
Telephone (H)	<input type="text"/>	Telephone (W)	<input type="text"/>
Cellphone	<input type="text"/>		
Email	<input type="text"/>		

The outcome of this application will be sent to you by email.

**2. Request for additional consultations and procedures (healthcare provider to complete)**

Your patient has automatic access to an annual treatment basket containing a limited number of consultations and procedures when approved for a chronic condition. Please complete the table below where the request is for further cover or for consultations or procedures not included in the treatment basket.

Condition	Consultation or procedure code	Number of consultations or procedures required per year	Supporting information for the request

**3. Appeal for funding for medicines, consultations or procedures that were declined (healthcare provider to complete)**

Please complete the table below where the request is for medicine, consultations or procedures previously not approved. Please provide supporting information for the request.

Condition	Medicine name and strength/ Consultation or procedure code	Quantity	Supporting information for the request

**4. Request for cover in full for non-formulary medicine (healthcare provider to complete)**

Please complete the table below where non-formulary medicine is prescribed for the treatment of PMB chronic conditions and the request is for cover without a co-payment. Please supply additional information and supporting documentation where appropriate, as to why the formulary medicine cannot be used by the patient, including details of treatment failure or adverse drug reactions where applicable.

Medicine name and strength	Quantity	Supporting information for the request

**Previous medicine history**

Medicine name and strength	Date treatment with this medicine was initiated	How long did the patient use the medicine for?	Details of treatment failures or adverse drug reactions

**5. Healthcare provider's details (healthcare provider to complete)**

Surname

First name(s)

BHF practice number  Speciality

Telephone

Email

The outcome of this application will be communicated to you by email.

Signature of provider

Date

 Please only sign if information is true, complete and correct.