

Request for additional cover for out-of-hospital Prescribed Minimum Benefit (PMB) conditions 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 number 1548, is a not-for-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). We take care of the administration of your membership for the Scheme.

Purpose of the form

This form should be completed when a member needs additional out-of-hospital treatment that falls outside of the basic level of care provided in the Prescribed Minimum Benefits (PMBs).

What you must do

- Complete the form in black ink and print clearly or complete it digitally. You can view the list of approved digital signature providers on www.medipos.co.za.
- All relevant sections must be signed by the patient.
- Your healthcare provider must complete section 2.1, 2.2, 2.3, 2.4 and section 3 to apply for treatment for a PMB.
- Please include detailed documentation to support your application. You can email the signed form with any supporting documentation to pmb.app.forms@medipos.co.za.
- You will receive an email informing you of our decision and the process you should follow.

1. Patient details

Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First name(s)	<input type="text"/>		
Preferred name	<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"/>		

Consent for processing my personal information

I give the Scheme and the Administrator consent to have access to and process all information (including general, personal, medical or clinical information) that is relevant to this application. I understand that this information will be used for the purposes of applying for and assessing my funding request for the Prescribed Minimum Benefits (PMB). I consent to the Scheme and the Administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical information) to my healthcare provider and to relevant third parties, to administer the Prescribed Minimum Benefits (PMB) as well as undertake managed care interventions related to the benefit.

Consent withdrawal for your disease management benefits

If you withdraw your consent for your general, personal, medical or clinical information to be accessed or shared with relevant third parties, this means that you will no longer have access to funding from the applicable disease management benefits. Claims which would usually be funded from the disease management benefits will, once consent is withdrawn, be funded from other available benefits according to the rules of your benefit option. Should you wish to continue with the consent withdrawal process, please call **0860 100 078**.

Signature of patient	<input type="text"/>	Date	<input type="text"/>
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(if patient is a minor, main member to sign)



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

2. Application (healthcare provider to complete)

Please complete the table below where the request is for further cover, or for consultations or procedures not included in the treatment basket.

Date of diagnosis

D	D	M	M	Y	Y	Y	Y
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2.1 Application for out-of-hospital treatment

Condition	ICD-10 code	Consultation or procedure code	Consultation or procedure description	Quantity required	Motivation

The professional billing codes must be supplied for us to review the application.

Please attach any relevant supporting documents, for example pathology tests.

Applications for psychotherapy:

- You are required to complete the psychotherapy treatment application on HealthID to proceed.
- If the application is for psychotherapy treatment for members younger than 13 years of age, the Scheme will require the latest Diagnostic and Statistical Manual of Mental Disorders (DSM V) form, including the Global Assessment of Functioning (GAF) score.
- Date of first psychotherapy session

D	D	M	M	Y	Y	Y	Y
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2.2 Application for medicine

Current medicine required (please provide supportive clinical results or information, where necessary)

Condition	ICD-10 code	Medicine name, strength and dosage	Consultation or procedure description	How long has the patient used this medicine?	
				Years	Months

2.3 Application for radiology

Condition	ICD-10 code	Procedure code	Procedure description	Quantity required

2.4 Application for pathology

Condition	ICD-10 code	Procedure code	Procedure description	Quantity required

3. Healthcare provider's details (healthcare provider to complete)

Surname														
First name														
BHF practice number											Speciality			
Telephone														
Email														

Notes to healthcare provider

- 3.1. Please ensure that the relevant ICD-10 diagnosis code(s) are used when you submit your claims to the Scheme to ensure payment from the correct benefit.
- 3.2. Please include the ICD-10 diagnosis code(s) when referring your patient to the pathologists and/or radiologists. This will enable them to include this information on their claims and allow us to pay claims correctly.
- 3.3. We will approve funding for medicine as per a defined list of medicine applicable to this benefit.
- 3.4. Please submit all the requested supporting documents with this application to prevent delays in the review process.
- 3.5. Should you make changes to your patient's treatment plan, you need to let us know, so that we can update their authorisation/s. You can do this by emailing the new prescription to us. If you or your patient do not let us know about changes to the treatment plan, we may not pay claims from the correct benefit.

Signature of healthcare provider

Date

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