

Application form

Out-of-hospital treatment of a prescribed minimum benefit (PMB) condition

IMPORTANT INFORMATION TO NOTE BEFORE COMPLETING THIS FORM

Transmed Medical Fund approves funding for benefits based on treatment protocols for PMB conditions, following guidelines from healthcare authorities and best clinical practices. Full funding may not be provided due to various factors. **This benefit is not applicable for Link Plan members.** Changes to an approved treatment plan will need a new application. Healthcare providers must include correct ICD-10 codes in claims.

How to apply for a PMB

- This form must be completed by you, the member, and your treating doctor. Please read each section carefully to make sure that you comply with all the requirements.
- Your benefits guide contains details of the chronic conditions and benefits that are covered and guidelines on how to access these benefits.
- Your treating doctor will assess your condition and may prescribe medication as per the Transmed Medical Fund medication formulary. To view the specific medication covered and check for any co-payments, visit https://secure.mediscor.co.za/adocs/schemeformularies/Transmed_Formulary_Lookup.html. If the medication is not on the formulary, please discuss possible changes to your medication with your treating doctor. It is crucial to always follow your doctor's guidance when it comes to your medication and treatment for your condition.
- The treatment that your doctor prescribes for your condition may also include consultations, pathology tests and/or radiology services.
- Before completing this form, please discuss your treatment plan with your doctor.
- Please return the completed and signed form, including any relevant information and supporting documents, by email to disease@transmed.co.za.
- We will review the application and, if approved, authorise benefits according to the Fund rules and clinical policies and inform you of our decision.
- If we authorise the medication prescribed by your doctor, you will need to obtain it from your network pharmacy.

PLEASE COMPLETE IN BLOCK LETTERS

Application for: ☐ New ☐ Renewal ☐ Change

1. MEMBER AND PATIENT INFORMATION

TO BE COMPLETED BY THE APPLICANT

Main member details

Membership number		Benefit option	☐ Select Plan	☐ Guardian Plan
Full name and surname				
ID number				
Race*	☐ African/Black	☐ Coloured/Mixed race	☐ Indian/Asian	☐ White/Caucasian
	☐ Other (please specify):		☐ I do not wish to disclose my race	
Contact number		Alternative contact number		
Email address				

* Optional information required by the Council for Medical Schemes (CMS) for statistical purposes.

1. MEMBER AND PATIENT INFORMATION (CONTINUED)

TO BE COMPLETED BY THE APPLICANT (CONTINUED)

Patient details

Dependant code			
Title		Initials	ID number
Full name and surname			
Race*	☐ African/Black ☐ Coloured/Mixed race ☐ Indian/Asian ☐ White/Caucasian ☐ Other (please specify): ☐ I do not wish to disclose my race		
Contact number		Alternative contact number	
	Kindly indicate your preferred day and time for contact (Monday to Friday between 8:00 and 16:00)		
Physical address			
		Code	
Email address			

* Optional information required by the Council for Medical Schemes (CMS) for statistical purposes.

Patient consent

I understand that Transmed Medical Fund and Momentum Health (Pty) Ltd, the Administrator, will maintain the confidentiality of my personal information and comply with the Protection of Personal Information Act 4 of 2013 (POPIA) and all existing data protection legislation, when collecting, processing and storing my personal information for the purposes of obtaining out-of-hospital treatment for PMB conditions. It is mandatory to provide contact details for all dependants aged 18 and older. The Fund will use these details to communicate directly with the patient or with you, as appropriate.

I understand that:

- Funding for this benefit is subject to meeting benefit entry criteria requirements, as determined by the Fund.
- The benefit provides cover for therapy clinically proven to be effective for my condition, which means that not all medication for the medical condition will automatically be covered.
- By registering for the benefit, I agree that my condition may be subject to disease management interventions and periodic review, and that this may include access to my medical records.
- Funding will only be effective once the Fund receives an application form that is completed in full.
- Payment to the healthcare professional for the completion of this form, on submission of a claim, will be subject to the Fund rules and where the beneficiary is a valid and active member at the service date of the claim.
- I agree to my information being used to develop registries. This means that you give permission for us to collect and record information about your condition and treatment. This data will be analysed, evaluated and used to measure clinical outcomes and to make informed funding decisions.
- To ensure that we pay your claims from the correct benefit, any claims from your healthcare providers must include the relevant ICD-10 diagnosis code(s). Please ask your doctor to also include the relevant ICD-10 diagnosis code(s) on the referral form for any pathology and/or radiology tests. This will enable the pathologists and radiologists to also include the relevant ICD-10 diagnosis code(s) on the claims they submit, thus further ensuring that we pay your claims from the correct benefit.

Consent for processing my personal information

1. I hereby acknowledge that Transmed Medical Fund has appointed Momentum Health (Pty) Ltd as the Administrator of this managed care programme and that any prescribed medical treatment shall be the sole responsibility of my attending medical practitioner/ treating doctor. I understand that the information provided on this form shall be treated as confidential and will not be used or disclosed except for the purpose for which it has been obtained.
2. I hereby give my consent to the Fund, Momentum Health (Pty) Ltd and its employees to obtain my or any of my dependants' special personal information (including general, personal, medical or clinical), whether it relates to the past or future (e.g. health and biometric) from any of my healthcare providers (e.g. pharmacist, pathologist, radiologist, treating doctor and/or specialist) to assess my medical risk, enrol me on the programme and to use such information to my benefit and to undertake managed care interventions related to my chronic condition(s).
3. I understand that this information will be used for the purposes of applying for and assessing my funding request for chronic benefits.
4. I give permission for my healthcare provider to provide the Fund and the Administrator with my diagnosis and other relevant clinical information required to review and process my application.
5. I consent to the Fund and the Administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical) to my healthcare provider, to administer the chronic benefits.

1. MEMBER AND PATIENT INFORMATION (CONTINUED)

TO BE COMPLETED BY THE APPLICANT (CONTINUED)

Consent for processing my personal information (continued)

6. Whilst Momentum Health (Pty) Ltd undertakes to take all reasonable precautions to uphold the confidentiality of information disclosed to it, I am aware that the Fund and my healthcare provider (where necessary) shall also gain access to the same information. I shall therefore not hold Momentum Health (Pty) Ltd and its employees or the Fund and its Trustees, liable for any claims by me or my dependants arising from any unauthorised disclosure of my special personal information to other parties.
7. I understand and agree that special personal information relevant to my current state of health may be disclosed to third parties for the purpose of scientific, epidemiological and/or financial analysis without disclosure of my identity.
8. I have the right to withdraw my consent to have my information accessed and processed, provided that the lawfulness of the processing of my information before my withdrawal will not be affected. Withdrawal of consent would, however, mean that I will no longer have access to funding from the relevant PMB.
9. The Fund's [Privacy Policy](#) is available on our website.

I, the undersigned, hereby declare that I have carefully read this application form, completed the applicable sections in full, and confirm that all the information provided herein is true and correct to the best of my knowledge. The answers that I have provided in this application are completed in full. I understand that if my application is approved, the information on this application will form the basis of such approval. I understand that it is my responsibility to ensure that the details provided in this application are true and complete, even if this application was completed by my financial adviser, healthcare provider or any other third party on my behalf.

Member/patient signature

- Signature of parent/legal guardian if patient is under the age of 18
- Signature of legal representative, next of kin, appointed curator or power of attorney if the patient is unable to sign due to incapacity or mental and/or physical disability

Date

2. MEDICAL PRACTITIONER'S INFORMATION

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER/TREATING DOCTOR

Doctor's details

Practice number		Speciality	
Full name and surname			
Healthcare facility	(if applicable)	Contact number	
Physical address			
		Code	
Email address			

3. CLINICAL INFORMATION

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER/TREATING DOCTOR

Clinical assessment

Sex	☐ Male	☐ Female	☐ Other	Weight	kg	Body mass index (BMI)	
				Height	cm	Waist circumference	cm
Blood pressure	Initial	mmHg	Date	DD/MM/YYYY			
	Present	mmHg	Date	DD/MM/YYYY			
Smoking/Vaping	☐ Never						
	☐ Ex	Started	MM/YYYY	Stopped	MM/YYYY	Average per day	
	☐ Present	Started	MM/YYYY	Average per day	☐ <3	☐ 3 to 20	☐ >20
Exercise	☐ Never	☐ <1 hour per week		Allergies	☐ Penicillin	☐ Aspirin	☐ Sulphonamides
	☐ 1 to 3 hours per week	☐ >3 hours per week		Other			

3. CLINICAL INFORMATION (CONTINUED)

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER/TREATING DOCTOR (CONTINUED)

Prescribed minimum benefit (PMB) condition(s) applied for

Diagnosis		Date of diagnosis	DD/MM/YYYY
ICD-10 code		Medication name	
Quantity		Strength	
Daily dose		Consultation or procedure code	
Number of repeats			

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ICD-10 code		Medication name	
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Diagnosis		Date of diagnosis	DD/MM/YYYY
ICD-10 code		Medication name	
Quantity		Strength	
Daily dose		Consultation or procedure code	
Number of repeats			

Please provide additional information on complications of condition(s)

Diagnosis		Date of diagnosis	DD/MM/YYYY
ICD-10 code			

Additional clinical details



If you think your patient is at risk of having HIV or has already been diagnosed, please contact the YourLife Programme on **0860 109 793** or by email at hiv@momentum.co.za. All correspondence is confidential.

3. CLINICAL INFORMATION (CONTINUED)

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER/TREATING DOCTOR (CONTINUED)

Application for radiology

Tariff description	Tariff code	Quantity

The quantity requested will be used as a guideline and the final, approved treatment plan will be communicated to the member.

Application for pathology

Tariff description	Tariff code	Quantity

The quantity requested will be used as a guideline and the final, approved treatment plan will be communicated to the member.

Proposed treatment plan

Number of consultations required per annum

Frequency of pathology required per annum

Frequency of radiology required per annum

The quantity requested will be used as a guideline and the final approved treatment plan will be communicated to the member.

Supporting clinical information and motivation

Relevant medical history (other health conditions, comorbidities, onset, severity and reversibility)

Relevant family history

3. CLINICAL INFORMATION (CONTINUED)

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER/TREATING DOCTOR (CONTINUED)

Supporting clinical information and motivation (continued)

Lifestyle and dietary programme details

Details of non-medication modalities to manage this patient

Please ensure that prescriptions for any medication prescribed for this patient is included with this application.

Declaration by attending medical practitioner/treating doctor

I, the undersigned, hereby confirm that the diagnoses listed herein match the medication and treatment that I have prescribed. This application form accurately reflects the treatment request. I understand that approval will depend on the information provided in this application and will form the basis for future requests for this member. I confirm that the information herein has been discussed with the member and/or their parents, legal guardian or other legal representative. As the treating doctor, I acknowledge my legal responsibility for the accuracy of this application and that Momentum Health (Pty) Ltd will rely on this information when recommending my patient's treatment.

I hereby declare that I have carefully read this application form, completed the applicable sections in full, and confirm that all the information provided herein is true and correct to the best of my knowledge.

Signature of attending medical practitioner/treating doctor

Date DD/MM/YYYY

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Integrated Care Programme

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