ENGEN Medical Benefit Fund

Administered by Discovery Health

Contact details

Tel: 0800 001 615 • PO Box 652509, Benmore 2010 • www.engenmed.co.za

Application for out-of-hospital management of a Prescribed Minimum Benefit condition

Who we are

Engen Medical Benefit Fund (referred to as 'EMBF'), registration number 1572, is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the administrator') is a separate company, an authorised financial services provider, and is responsible for the administration of your membership on behalf of the Fund.

About this form

This form should be completed when a you require out-of-hospital management of a Prescribed Minimum Benefit condition.

How to complete this form

Please ensure that all the relevant information required, as set out in the form is completed, including contact details for the provider and date of request.

1. Please use one letter per block, complete in black ink and print clearly.
2. You (the member) must complete sections 1 and 2 of this form.
3. Your healthcare professional must complete sections 3 and 4 for treatment of a Prescribed Minimum Benefit condition. Please include detailed documents supporting your application.
4. Please email this completed and signed form with any detailed supporting documents to **PMB_APP_FORMS@engenmed.co.za.**
5. Once we have processed your application, you will receive a letter informing you of our decision and the process you should follow for claims submission.

1. Important patient information

Title

Surname

First name/s

ID Number Gender M F

Membership number

Telephone (H) Telephone (W)

Cellphone

Email

2. Declarations

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 my application. I give permission for the Fund and the administrator to collect and record information about my condition and treatment. This data will be analysed, evaluated and used to measure clinical outcomes and make informed funding decisions.

I understand that:

2.1. Funding from Prescribed Minimum Benefits is subject to meeting benefit criteria in line with Council for Medical Schemes' guidelines.

2.2. The Prescribed Minimum Benefits provide cover for disease-modifying therapy only, which means that not all medicines for a listed condition are automatically covered by Prescribed Minimum Benefits.

2.3. Funding for treatment from Prescribed Minimum Benefits will only be effective from when Engen Medical Benefit Fund receives an application form that is completed in full.

2.4. An application form needs to be completed when applying for a new Prescribed Minimum Benefit condition.

If you are approved on the benefit, you need to let us know when your treating doctor changes your treatment plan so that we can update your Prescribed Minimum Benefit authorisation/s. You can do this by emailing the new prescription to us or asking your doctor or pharmacist to do this for you.

To make sure that we pay your claims from the correct benefit, we need the claims from your healthcare providers to be submitted with the relevant ICD-10 diagnosis code(s). Please ask your doctor to include your ICD-10 diagnosis code(s) on the claims they submit and on the form that they complete when they refer you to the pathologists and/or radiologists for tests. This will enable the pathologists and radiologists to include the relevant ICD-10 diagnosis code(s) on the claims they submit, ensuring that we pay your claims from the correct benefit.

Agreement and consent

By registering for Prescribed Minimum Benefits, 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.

I give the Fund 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 Prescribed Minimum Benefits. I consent to the Fund and the administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical information) to my treating doctor and to relevant third parties, to administer the Prescribed Minimum Benefits as well as undertake managed care interventions related to the PMB condition. I understand that withdrawing consent for my general, personal, medical or clinical information to be accessed or shared with relevant third parties, means that I 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 benefit rules. (Should you wish to withdraw consent, then please call **0800 001 615**).

Patient's signature ______________________ Date D D M M Y Y Y Y

(If patient is a minor, principal member to sign)

I acknowledge that I have read and understood the conditions under “Declarations”.

3. Application (Healthcare provider to complete)

3.1. Application for out-of-hospital treatment*

Condition	Date of diagnosis	ICD-10 Code	Consultation or procedure code**	Consultation or procedure description	Quantity required

* Clearly specify what is required, for example consultations, pathology, radiology and/or procedure.
** 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:

- If the application is for psychotherapy treatment for members younger than 13 years of age, the Fund will require the latest Diagnostic and Statistical Manual of Mental Disorders (DSM V) form including the World Health Organisation Disability Assessment Schedule - Children and Youth version (WHODAS-Child) form.
  Date of 1st psychotherapy session D D M M Y Y Y Y
- Internet-based Cognitive Behavioural Therapy (iCBT) has been demonstrated to be a helpful adjunct to treatment for people with Major Depression*. An iCBT course is included in the treatment basket for Major Depression for Engen Medical Benefit Fund members who are 18 years and older. iCBT will be funded as one (1) psychotherapy consultation from the Out-of-Hospital Treatment of a Prescribed Minimum Benefit, where PMB funding is approved. We will let qualifying members know that they have access to an iCBT course.

  Please indicate if you feel that information on iCBT should not be shared with this member.

  This member should not receive information on iCBT ☐

  If no preference is indicated, the member will be given more information on the iCBT course.
  *ICD-10 codes: F32.2; F32.3; F32.8; F32.9; F33.0; F33.1; F33.2; F33.3; F33.4; F33.8; F33.9, F34.0; F34.1; F53.1; F53.8; F53.9

3.2. Application for medicine

Medicine requested (please provide supportive clinical results or information, where necessary)

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

3.3. Application for radiology

Condition	ICD-10 code	Procedure code	Procedure description	Quantity required

3.4. Application for pathology

Condition	ICD-10 code	Procedure code	Procedure description	Quantity required

4. Healthcare provider's details (Healthcare provider to complete)

Name and surname

BHF practice number

Speciality

Telephone

Email address

Notes to Healthcare provider

4.1. Please ensure that the relevant ICD-10 diagnosis code(s) is used when you submit your claims to the Fund to ensure payment from the correct benefit.

4.2. Please include the ICD-10 diagnosis code(s) when referring your patient to the pathologists and/or radiologists. This will enable the pathologists and radiologists to include this information on their claims and allow us to comply with legislation by paying Prescribed Minimum Benefits (PMB) claims correctly.

4.3. We will approve funding for generic medicine, where available, unless you have indicated otherwise.

4.4. Please submit all the requested supporting documents with this application to prevent delays in the review process.

4.5. Should you make changes to your patient's treatment plan, you need to let us know so that we can update their PMB 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.

Healthcare provider's signature

Date D D M M Y Y Y Y