APPLICATION FORM:
OUT OF HOSPITAL MANAGEMENT OF PMB's

1. This form is only for registration of out of hospital prescribed minimum benefits (PMB) conditions. (Do not use this form for conditions listed under the CDL or Additional Chronic Conditions).
2. This form is only for registration of an initial or newly diagnosed PMB condition. For any changes to medication for an existing approval, please fax the prescription with the relevant ICD-10 codes to 011 707 8471
3. One form must be completed per patient.
4. Once completed please email or fax to:

   Email: rdw.medicine@sanlamhealth.co.za

   Fax no: 011 707 8471
5. Forms not completed in full will not be processed.
6. Section 1 of the application form must be completed by the member.
7. Sections 2 and 3 must be completed by your doctor.
8. Approval of any PMB condition and medicine is subject to clinical entry criteria and drug utilisation reviews.
9. For queries relating to this benefit please email us at rdw.medicine@sanlamhealth.co.za
10. Attach copies of any reports to support the diagnosis of chronic conditions, where applicable.

1. PATIENT INFORMATION (Please tick the applicable box)

Surname | Initials

Full Name(s)

RSA Identity No. | Gender (M=Male; F=Female)

Date of Birth (D D M M C C Y Y)

Telephone:

Home Code | No. | Cell No.

Work Code | No. | Fax Code | No.

E-mail Address

We can contact you for feedback on your application via email ☐ or fax ☐

I understand that my application will not be processed if the information on this form is incomplete or the relevant diagnostic results are not provided to Sanlam Health. I give permission to my doctor to provide Sanlam Health with my diagnosis and other relevant clinical information to review my application.

Principal Member Signature | Patient Signature (unless a minor) | Date

Sanlam

RAND WATER

Membership No: | | | | | | | | |

2. PMB APPLICATION (DOCTOR TO COMPLETE)

2.1 PMB Condition Applied for:

ICD 10 Code	PMB Code	PMB Description	Date of Diagnosis	Ongoing / Acute Medical Management*

* Please confirm whether this condition is for acute or ongoing medical management.

2.2 Medicine Application

ICD 10 Code	Medicine name and Strength	Dosage	Quantity per month	Number of Months

2.3 Procedures Application

List all consultations, pathology, radiology, procedures and any other treatment required out of hospital

ICD 10 Code	Tariff Code	Tariff Description	Quantity	Start Date

3. DOCTOR DETAILS

Name | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

BHF Practice Number | | | | | | | | | Speciality _____

Telephone Number | | | | | | | | | | | |

Fax Number | | | | | | | | | | | |

Doctor's Signature _____ Date | D | D | M | M | C | C | Y | Y |

1. Please ensure all relevant reports and / or tests are included with this application form.
2. For completion of this application form use claim code 0199. Please remember to use the relevant ICD 10 code with the claim.
3. This form only needs to be completed when applying for a new chronic condition. For any changes to the patient's medicine for approved conditions please call 0861 11 44 76.