GEMS PMB Request Form

Out of Hospital



Important to note: This form is not for oncology treatment, appliance request	s or chronic medication requests. Please allow up to 10 business days for review.
 Purpose of this form: This form is for the prospective applications for out-of-hospital services to be reviewed for funding as Prescribed Minimum Benefit (PMB). Chronic medicine: to be authorised through the Chronic Medicine process: Tel: 0800 004 367 (member and provider) Fax: 0861 004 367. Oncology management: register the member by submitting the proposed treatment plan by fax 0861 004 367 or email enquiries@gems.gov.za. 	Attach all relevant special investigations and lab results to this form when submitting. Submit form via fax 0861 004 367, or email at enquiries@gems.gov.za Indicate purpose of form: Please tick the appropriate box and fill in the relevant sections New Treatment Plan (A, B, D, E) Motivation for extra treatment (A, B, D, E) Motivation for waive rules on non-DSP usage (A-D)
Section A: Membership Details	
Patient Details	
Surname:	_ First Name:
Member Number: Dependant	Code: Option/Plan:
Date of Birth: D D M M Y Y Y Y	ID Number:
Daytime Contacts Details: Email A	ddress:
Section B: Treatment Healthcare Provider Deta	ills
Details of the doctor who will be providing the ongoing care	
Surname:	Initials:
Practice Number:	Speciality:
Tel:	_ Fax:
Cell:	Email [.]

Section C: Motivation to Waive Rules on Non-DSP

A DSP is a healthcare provider or group of providers who have been selected by the Scheme to provide diagnosis, treatment, and care for its members with respect to PMB conditions. If you choose to use a healthcare provider other than the DSP for the treatment of a PMB condition, the Scheme may impose a co-payment or limit the rate at which claims are eimbursed. The application to waive the non-DSP override will not be considered unless sufficient proof is provided that treatment at the DSP could not be reasonably accessed.

Please select one of the reasons for the waiver request below.

- Service not available from DSP/could not be provided without unreasonable delay.
- Immediate (emergency) treatment required under circumstances where DSP could not be readily accessed.
- DSP not within reasonable proximity.

Section D: Patient Consent

• I understand that all personal clinical information supplied to the GEMS PMB Programme will be used to determine access to specific benefits for PMB conditions. The programme's medical staff will review this information in order to make recommendations regarding the provision of these benefits. My/my dependant/s healthcare provider, however, retains responsibility for my/my dependant/s care, irrespective of the benefits so authorised.

• I/we therefore, authorise any healthcare provider, hospital, clinic, laboratory and/or medical facility in possession of any medical information regarding myself (the applicant) or any dependant (including newborn baby), to provide the GEMS PMB Programme with information that it may require. I warrant that the information in this application form is correct. I acknowledge that I will be responsible for any co-payments as per Scheme rules or payment for any medication and/or investigations not authorised by the GEMS PMB team.

• I understand and agree that medical information relevant to my current state of health can be used for the purpose of scientific, epidemiological and/or financial analysis without disclosure of my identity. I acknowledge that benefits authorised by the GEMS PMB Programme are subject to managed care guidelines. I am aware that more information on the PMBs can be obtained from the Scheme and the Council for Medical Schemes (CMS).

Patient's Signature	Date:	D	D	Μ	Μ	Y	Y	Y	Y

Name and Surname:

Private bag X782 Cape Town • Service Provider Call Centre: 0860 436 777 • Fax: 0861 00 GEMS (4367) Email enquiries@gems.gov.za • Fraud Line 0800 21 2202 • HIV Aids Helpline 0860 436 736 • www.gems.gov.za 1

The Government Employees Medical Scheme (GEMS) is an authorised Financial Services Provider (FSP No 52861)

Section E: Full Treatment Plan

Details to be completed by the treating healthcare provider.

*Procedure or Consultation; nappi code for acute medicine; etc.

ICD-10	PMB Condition	*Code	Description	No. per year	Motivation
eg: I10	Hypertension	0190	Consultation	3	BP 160

Doctor's Signature

Date: D D M M Y Y Y Y

Name and Surname:

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