GEMS PMB request form

out-of-hospital treatment

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- **Chronic medicine:** To be authorised via the Chronic Medicine process. Tel: **0860 00 4367** (member and provider) Fax: **0861 00 4367**
- **Oncology management:** Register member by submitting proposed treatment plan by fax **0861 00 4367** or email **enquiries@gems.gov.za**
- **Attach all relevant** special investigations and lab results to this form when submitting
- **Submit form** via fax **0861 00 4367** or email **enquiries@gems.gov.za**

Indicate purpose of form:

(Please tick appropriate box and fill in relevant sections)

☐ **New treatment plan**
(Complete sections A, B, D, E)

☐ **Motivation for additional treatment**
(Complete sections A, B, D, E)

☐ **Motivation to waive rules on non-DSP usage**
(Complete sections A, B, C, D)

Section A: Membership details

Patient details

Surname

Full name/s

Membership no Dependent code

Option/plan Date of birth D D M M Y Y Y Y

ID no Daytime contact details Tel (W) ( )

Email

Section B: Treating healthcare provider details

Details of the doctor who will be providing the ongoing care

Initials

Surname

Practice no Speciality

Tel no (W) ( ) Fax no (W) ( )

Cellphone no

Email

Section C: Motivation to Waive Rules on non-DSP usage

A DSP is a healthcare provider or group of providers who have been selected by the GEMS to deliver the diagnosis, treatment and care in respect of PMB conditions to its members. If you choose to use a healthcare provider other than the DSP for the treatment on a PMB condition, GEMS may impose a co-payment or limit the rate at which claims are reimbursed. The application to waive the non-DSP co-payment 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.

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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 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 dependent (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 medicine 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 M M Y Y Y Y

Name and surname _____

Section E: Full treatment plan

Details to be completed by treating healthcare provider.
* Please include procedure or consultation tariff, or Nappi code for specific medicine, etc.
** All additional/adjusted quantities in the current services are authorised for a calendar year, should a service or higher quantity be required annually, please indicate as such in the last column with supporting documentation.

ICD-10	PMB condition	*Code	Description	No. per year	Motivation	Annually (Y/N)
eg:I10	*Hypertension*	*0190*	*Consultation*	*3*	*BP 160/110*	

Doctor's signature _____ Date D D M M Y Y Y Y

Name and surname _____

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