# GEMS PMB Programme

## Application Form - Confidential

## SECTION A: MEMBERSHIP DETAILS

**PRINCIPAL MEMBER DETAILS**

Full first name ______________________________

Surname ______________________________

Medical Scheme ______________________________ Gender ☐ M ☐ F

Member number ☐☐☐☐☐☐☐☐☐ Option/Plan ______________________________

**PATIENT DETAILS**

Patient's surname ______________________________ Dependant code ☐☐

Full first name ______________________________ Gender ☐ M ☐ F

Date of birth D D M M Y Y Y Y ID number ☐☐☐☐☐☐☐☐☐☐☐☐☐

Postal address ______________________________

______________________________

______________________________ Code __________

Tel no (H) ( ______ ) ______________________________ (W) ( ______ ) ______________________________

Cell phone ______________________________ Fax no ( ______ ) ______________________________

Email ______________________________

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).

Principal Member's signature ______________________________ Date D D M M Y Y Y Y

## SECTION B: TREATING HEALTHCARE PROVIDER DETAILS

### DETAILS OF THE DOCTOR WHO WILL BE PROVIDING ONGOING CARE

Healthcare provider's surname ______________________ Initials __________

Practice number ______________ Speciality ______________________

Postal address ____________________________________________

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____________________________________________ Code ______

Physical address ____________________________________________

____________________________________________

____________________________________________ Code ______

Tel no ( ______ ) ______________ Fax no ( ______ ) ______________

Cell phone ______________________ Email ______________________

## SECTION C: TREATMENT (to be completed by the healthcare provider)

### CLINICAL HISTORY

Please specify the condition for which you are requesting access to PMB benefits.

| Condition | ICD 10 | Registered on chronic? | | When was diagnosis first made? |
|---|---|---|---|---|
| | | YES | NO | YEAR |
| | | YES | NO | YEAR |
| | | YES | NO | YEAR |

### TREATMENT PLAN

| Condition | Procedure or consultation NHRPL tariff code | Procedure or consultation description | Number of procedures or consultations required per year |
|---|---|---|---|
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## SECTION C: TREATMENT (continued)

### ACUTE MEDICATION

| Condition | Drug name | Drug strength | Period required | Quantity |
|---|---|---|---|---|
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**Note:** Chronic medicine to be authorised via the chronic medicine process (Member tel: 0860 00 4367; Provider tel: 0860 10 0608, fax: 0866 51 8009)

### CLINICAL MOTIVATION

Please provide a brief outline of the reason for application.

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### CONDITION SPECIFIC CLINICAL RESULTS

Please provide relevant clinical data in support of motivation.

| Condition | Date of test | Name of test | Result |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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

## SECTION D: MOTIVATION TO WAIVE NON-DSP RULES

A DSP is a healthcare provider or group of providers who have been selected by the Scheme 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 of a PMB condition, the Scheme may impose a co-payment or limit the rate at which claims are reimbursed.

**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

**Additional information in support of request:**
Please note that 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.

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**PLEASE FAX TO 0861 00 4367**

Name and surname ______________________________________________



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