

C Please specify the condition for which you are requesting additional benefits

Condition
ICD – 10 Code

D Details of the attending medical practitioner

Practice number
Surname Title
Full names Initials
Physical address
Postal address Postal code
Telephone number (h) Telephone number (w)
Cellphone number
Fax number
E-mail address

E Motivation (please provide a brief outline of your condition)

When were you diagnosed with this condition?
What treatment (medication, etc) are you currently taking?
When was the last time you visited your GP for this condition?
Do you smoke? YES NO Indicate your level of physical activity

By completing this application form, you are applying for benefits to manage your PMB condition in accordance with legislation and the Selfmed scheme rules. This is, however, not an application for chronic medicine benefits. To obtain chronic medicine authorisation, please request your treating physician to phone Selfmed on 0860 247 288.

I/we understand that all personal and clinical information supplied will be kept confidential. The information will be used to determine the patient's eligibility for additional benefits (and the reimbursement thereof) in order to manage their condition.

I/we hereby authorize any medical practitioner and/or medical facility in possession of any medical information with regards to my medical condition to provide the managed healthcare provider of Selfmed Medical Scheme from time to time, with such information as they may require.

Signature: Member Signature: Patient (not required if patient is a minor)

Date