

# Reconstructive treatment and surgery pilot application form 2023

Discovery Health Medical Scheme Executive and Comprehensive plans only



## Contact us

Tel (members): 0860 99 88 77, Tel (health partners): 0860 44 55 66, [www.discovery.co.za](http://www.discovery.co.za), PO Box 784262, Sandton, 2146, 1 Discovery Place, Sandton, 2196.

## Purpose of the form

This application form is for members on the Executive and Comprehensive plans to apply for cover for non-functional and/or reconstructive treatment and/or surgery on the pilot. This form must be completed by the main member. Please make sure you are using the most up-to-date form. Download the latest version of all forms from [www.discovery.co.za](http://www.discovery.co.za) > Medical Aid > Manage your plan > Find important documents and certificates.

## What you must do

- Fill in the form in black ink and print clearly, or complete the form digitally.
- All relevant sections must be physically signed by the patient and or treating doctor and cannot be signed digitally. The patient and or treating doctor must sign and date any changes.
- To avoid administrative delays, please include all relevant supporting documentation with your application, as described in Section 4. Send the completed and signed form with any supporting documentation to us by email at [benefitauthinfo@discovery.co.za](mailto:benefitauthinfo@discovery.co.za).

### 1. Main member details

Membership number	<input type="text"/>		
Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First name(s) (as per identity document)	<input type="text"/>		
Preferred name	<input type="text"/>		
Gender	<input type="checkbox"/> M <input type="checkbox"/> F	Date of birth	<input type="text"/>
ID or passport number	<input type="text"/>	Country of issue	<input type="text"/>
Previous or maiden	<input type="text"/>	Marital status	<input type="text"/>
Telephone (W)	<input type="text"/>	Telephone (H)	<input type="text"/>
Cellphone	<input type="text"/>		
Email	<input type="text"/>		

The outcome of this application will be communicated to you by email.

### 2. Patient's details

Title	<input type="text"/>	Initials	<input type="text"/>
First name(s) (as per identity document)	<input type="text"/>		
Preferred name	<input type="text"/>	Gender	<input type="checkbox"/> M <input type="checkbox"/> F
Date of birth	<input type="text"/>		
ID or passport number	<input type="text"/>	Country of issue	<input type="text"/>
Relationship to member	<input type="text"/>		

### 3. Referring healthcare professional's details

Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First name(s) (as per identity document)	<input type="text"/>		
BHF practice number	<input type="text"/>	Telephone member	<input type="text"/>

#### 4. About your condition and requested procedure

Date of the procedure 

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Where will the procedure be done?    In hospital     In a day clinic

Name of facility

BHF practice number 

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##### 4.1. Your diagnosis and details of the planned procedure

Please supply details of the diagnosis and the proposed procedure from the treating or referring doctor. Please provide as much information as possible, including letter of motivation, quotation, procedure codes, relevant laboratory results as well as ultrasound reports and colour photographs where relevant and appropriate.


##### 4.2. Details of all the healthcare providers who will be involved with the planned procedure

###### Surgeon

BHF practice number	Procedure code	Rand value																				
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###### Anaesthetist

BHF practice number	Procedure code	Rand value																				
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###### Assistant

BHF practice number	Procedure code	Rand value																				
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**Physiotherapist**

BHF practice number	Procedure code	Rand value
		R
		R
		R
		R
		R

**Laboratory**

BHF practice number	Procedure code	Rand value
		R
		R
		R
		R
		R

**Radiologist**

BHF practice number	Procedure code	Rand value
		R
		R
		R
		R
		R

**Any other providers relevant to the planned procedure**

Registration/BHF practice number	Procedure code	Rand value
		R
		R
		R
		R
		R

## 5. Member declaration

I,  (patient's name in full),  
hereby give Discovery Health Medical Scheme and Discovery Health (Pty) Ltd consent to the collection of all medical/clinical information  
pertaining to my application for  (name of medicine/  
procedure/test) for the treatment of  (name of condition)  
as requested either from myself or my consulting doctor,  (doctor's name in full)

I understand that review of this application is not a guarantee of payment and that Discovery Health Medical Scheme may not confirm any benefits for the requested procedure.

I also understand that the pilot is subject to a limit and that there will be a 20% co-payment on all the accounts related to the procedure that is approved for payment, and that I will personally be responsible for this. I acknowledge that I need to pay the outstanding amount from my pocket.

### Consent for processing my personal information

I give the Scheme and the administrator consent to have access to and process all information (including general, personal, medical or clinical information) that is relevant to this application. I understand that this information will be used for the purpose of applying for and assessing this reconstructive treatment and surgery pilot application. I consent to the Scheme and the administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical information) to my healthcare provider and to relevant third parties pertaining to this reconstructive treatment and surgery pilot application.

Member's signature

Date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---



**Please only sign if information is true, complete and correct.**

Patient's signature

Date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---



**Please only sign if information is true, complete and correct.**

(If patient is a minor, main member to sign)