Reconstructive treatment and surgery pilot application form 2025

Discovery Health Medical Scheme Executive and Comprehensive plans only

Discovery Health Medical Scheme

Who we are

Discovery Health Medical Scheme, registration number 1125, is a not-for-profit organisation registered with the Council for Medical Schemes, and is the medical scheme you are a member of.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Discovery Health Medical Scheme and takes care of the administration of your membership.

Contact us

Tel (members): **0860 99 88 77**, Tel (health partners): **0860 44 55 66**, **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** > 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 treating doctor and cannot be signed digitally.
- Fill in section 1 to 3 of the application form and sign section 4.
- Only applications signed by the treating doctor will be accepted.
- Please return the completed application form to us by email to **Benefitauthinfo@discovery.co.za**
- The treating doctor and the patient will receive a letter informing them of our decision and what to do next for approved requests.
- You may call us if you would like to lodge a formal dispute or if you wish to appeal a decision.

1. Main member details

Title | Initials

Surname

First name(s) (as per identity document)

Previous/maiden name

ID or passport number | Membership number

Gender M F | Date of birth D D M M Y Y Y Y

Marital status Married Single Divorced Widowed

Telephone (W) | Telephone (H)

Cellphone

Email

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

2. Patient's details

Title | Initials

First names

Surname

ID or passport number | Membership number

Telephone (H) | Telephone (W)

Cellphone

Email

Relationship to main member

Please note that this form expires on 31/03/2026. Updated forms are always available at www.discovery.co.za under **Medical Aid** > **Find documents and certificates**.

DHMRTS001

3. Referring healthcare professional's details and declaration

Title | Initials

Surname

First name(s) (as per identity document)

BHF practice number | Telephone number

1. Approval of this application for the Reconstructive Treatment and Surgery Pilot is based on the member's plan type (only available to Executive and Comprehensive Plans) and subject to clinical review.
2. Health Professional Direct Payment Arrangement agreements will apply with payment up to the agreed payment arrangement amount for contracted providers.
3. Professional fees for non-contracted providers will be funded at the Discovery Health Rate (DHR) relevant to the member's plan type.
4. We pay up to a maximum of 80% of the member's plan cover, up to an overall limit based on the procedure performed. The member will need to pay the balance of the incurred costs and any amount in excess of the Discovery Health Rate (DHR) and the overall limit.

Healthcare professional's signature | Date D D M M Y Y Y Y

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

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
		R .
		R .
		R .
		R .
		R .

Anaesthetist

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

Anaesthetist

BHF practice number	Procedure code	Rand value
		R .

Assistant

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

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 .

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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.

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

(If patient is a minor, main member to sign)
Please only sign if information is true, complete and correct.