Request for additional cover for out-of-hospital Prescribed Minimum Benefit conditions 2025

LA Health
Powered by Discovery

Contact details
Tel: 0860 103 933 • PO Box 652509, Benmore 2010 • www.lahealth.co.za

Who we are

LA Health Medical Scheme (referred to as 'the Scheme'), registration number 1145, is a not-for-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Scheme.

The latest version of the application form is available on www.lahealth.co.za. Alternatively, members can call 0860 103 933 and healthcare professionals can call 0860 44 55 66 for us to send the latest form.

About this form

This form should be completed when a member needs out-of-hospital treatment that falls outside of the basic level of care provided for in the Prescribed Minimum Benefits.

Please only complete this form if we have already reviewed a request for funding for your condition as a Prescribed Minimum Benefit. Otherwise please complete the Application for out-of-hospital management of a Prescribed Minimum Benefit condition form for review.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. You (the member) must complete sections 1 and 2 of this form.
3. Your healthcare professional must complete sections 3 and 4 and include detailed documents to support this application for treatment of a Prescribed Minimum Benefit condition.
4. Please email this completed and signed form with any supporting documents to **PMB_APP_FORMS@lahealthms.co.za**.
5. You will receive a letter informing you of our decision and the process you should follow.

1. Patient details

Title | | Initials

Surname

First name(s) (as per identity document)

ID or passport number | | Membership number

Telephone (H) | | Telephone (W)

Cellphone

Email address

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

2. Member's declaration

I give permission for my healthcare professional to provide LA Health Medical Scheme with my diagnosis and other relevant clinical information required to review my application for Prescribed Minimum Benefits. I consent to LA Health Medical Scheme and Discovery Health (Pty) Ltd disclosing from time to time, information supplied to LA Health Medical Scheme and Discovery Health (Pty) Ltd (including general or medical information that is relevant to my application) to my healthcare provider, to administer my benefits. I agree that LA Health Medical Scheme may disclose this information at its discretion but only as long as all the parties involved have agreed to always keep the information confidential.
I understand that:

2.1. Funding from the Prescribed Minimum Benefit is subject to benefit entry criteria as determined by LA Health Medical Scheme.
2.2. Each case will be assessed on its own merit.
2.3. By registering for the Prescribed Minimum Benefits, I agree that my condition may be subject to disease management interventions and periodic review and this may include access to my medical records.
2.4. Treatment approved as a Prescribed Minimum Benefit will only be effective from when LA Health Medical Scheme receives an application form that is completed in full.
2.5. The covered Prescribed Minimum Benefit conditions and clinical entry criteria may change from time to time and I may need to send an updated or new application form if LA Health Medical Scheme or Discovery Health (Pty) Ltd asks for this.

2.6. Withdrawing consent for my general, personal, medical or clinical information to be accessed or shared with relevant third parties, means that I will no longer have access to funding from the applicable disease management benefits. Claims which would usually be funded from the disease management benefits will, once consent is withdrawn, be funded from other available benefits according to the rules of my benefit option. Should I wish to withdraw consent, I will then call **0860 103 933**.

Patient's Signature ____________________ Date D D M M Y Y Y Y

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

I acknowledge that I have read and understood the conditions under "Notes to member" (section 2).

3. Application (healthcare professional to complete)

Date of diagnosis D D M M Y Y Y Y

3.1. Application for out-of-hospital treatment*

Condition	ICD-10 code	Consultation or procedure code**	Consultation or procedure description	Quantity required

*Please clearly specify what is required, for example consultations, pathology, radiology and/or procedure.
**The professional billing codes must be supplied for us to review the application.

Please attach any relevant supporting documentation, for example pathology tests. If the application is for psychotherapy treatment for members younger than 13 years of age, the Scheme will require the latest Diagnostic and Statistical Manual of Mental Disorders (DSM V) form including the World Health Organization Disability Assessment Schedule - Children and Youth version (WHODAS-Child) form.

3.2. Application for medicine

Current medicine required (please provide supportive clinical results or information, where necessary)

Condition	ICD-10 code	Medicine name, strength and dosage	How long has the patient used this medicine?	
			Years	Months

3.3. Application for radiology

Condition	ICD-10 code	Procedure code	Procedure description	Quantity required

Please note that this form expires on 31/03/2026. Up to date forms are available on www.lahealth.co.za.

LA Health Medical Scheme, registration number 1145, is administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07. Discovery Health (Pty) Ltd is an authorised financial services provider.

3.4. Application for pathology

Condition	ICD-10 code	Procedure code	Procedure description	Quantity required

4. About the Doctor

Name and Surname

Practice number

Speciality

Telephone

Email

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

Doctor's signature

Date D D M M Y Y Y Y