Application for additional allied, therapeutic and psychology cover 2018

Executive, Comprehensive and Priority Plans only

Discovery Health Medical Scheme

Contact us

Tel (Members): 0860 99 88 77, Tel (Health partners): 0860 44 55 66, PO Box 784262, Sandton, 2146, www.discovery.co.za

Who we are

Discovery Health Medical Scheme (referred to as 'the Scheme'), registration number 1125, is the medical scheme. This is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the administrator') 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.

Purpose of the form

This application form is for members on the Executive, Comprehensive and Priority Plan to apply for additional allied, therapeutic and psychology cover.

What you must do

- Fill in the form in black ink and print clearly, or complete the form digitally by using Microsoft Word.
- All relevant sections must be physically signed by the applicant and cannot be signed digitally. The applicant must sign and date any changes.
- Member must complete section 1 and section 2
- Sign section 1 of the application form
- Read "Important information" section on page 2
- Take the application form to your healthcare professional to complete the relevant sections
- Fax the completed application form to **011 539 2860**, email it to **ATmotivations@discovery.co.za**, or post it to Discovery Health Medical Scheme, PO Box 784262, Sandton 2146.

Please note: Due to confidentiality, the patient's name is excluded, however, please make sure that you include the patient's date of birth.

1. Patient information (to be completed by the patient)

Title _____ Surname _____

First name(s) _____

Gender ☐ M ☐ F Identity number N N N N N N N N N N N N N Member number N N N N N N N N N

Telephone (H) _____ _____ Telephone (W) _____ _____

Cellphone _____ _____ Fax _____ _____

Email _____

Signature of patient (if patient is a minor, main member or guardian to sign) _____ Date Y Y Y Y M M D D

I acknowledge that I have read and understood the conditions for additional benefits under "Important information" (Section 3), on page 2.

2. Details of healthcare professionals you currently visit

2.1. List all healthcare professionals not included in the application form (for example: GPs, specialists, other allied, therapeutic and psychology professionals)

Name	Discipline

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Details of healthcare professionals you currently visit (continued)

2.2. Current medicine the patient is on, relevant to the primary diagnosis

3. Important information

I give permission for my healthcare professional to provide Discovery Health Medical Scheme and Discovery Health (Pty) Ltd (as administrator) with my diagnosis and other relevant clinical information required to review my application for additional allied, therapeutic and psychology benefits.

I understand that:

3.1. Funding for additional allied, therapeutic and psychology services is subject to meeting benefit entry requirements as determined by Discovery Health Medical Scheme.

3.2. Funding for additional allied, therapeutic and psychology services will only be effective once I have reached the annual Allied and Therapeutic Benefit limit applicable on my plan type.

3.3. The outcome of the decision will be sent via email to the members email address as listed on our records.

3.4. Only services from acousticians, biokineticists, chiropractors, occupational therapists, physiotherapists, psychologists, social workers (in mental health) and speech-language therapists and audiologists will be considered for funding.

3.5. Discovery Health Medical Scheme will pay the claims for the approved additional allied, therapeutic and psychology services from the available funds in my Medical Savings Account according to the payment option I selected. Once I reached the Above Threshold Benefit, all of the approved allied, therapeutic and psychology claims will pay at 100% of the Discovery Health Rate.

3.6. For Priority Plans, these claims will be subject to the Above Threshold Benefit limit.

3.7. Members on the Classic Comprehensive Zero MSA plan, need to reach the Annual Threshold to have cover for day-to-day medical expenses.

3.8. Funding for additional healthcare services will be effective from when Discovery Health Medical Scheme receives a completed, signed form.

3.9. The approved additional allied, therapeutic and psychology benefits only applies for the dependant whose date of birth is on the application form.

3.10. I may need to send an updated or new application form, if required by Discovery Health Medical Scheme or its advisory panels (representatives from the relevant professional body).

3.11. Consent for processing my personal information:

3.11.1. I give the Scheme and Administrator consent to have access to and process all information (including general, personal, medical or clinical information) that is relevant to this application.

3.11.2. I understand that this information will be used for the purposes of applying for and assessing my funding request for additional allied, therapeutic and psychology services.

3.11.3. I give permission to the Scheme and Administrator to share my medical and clinical information with the external advisory panel, should the need arise.

3.11.4. I consent to the Scheme and Administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical information) to my healthcare provider, to administer the additional allied, therapeutic and psychology benefits.

4. Notes to healthcare professional

4.1. The healthcare professional's fee for completion of this form will be reimbursed as per their relevant report writing billing code and/or billing guidelines, on submission of a separate claim. Payment of the claim is from the day-to-day benefits (if applicable to the member's plan type), subject to Discovery Health Medical Scheme rules and availability of funds and where the member is a valid and active member at the service date of the claim.

4.2. In line with legislative requirements, please ensure that when using your report writing billing code, you submit the ICD-10 diagnosis code(s). As per industry standards, the appropriate ICD-10 code(s) to use for this purpose would be those reflective of the actual condition(s) for which the form was completed. If funding for multiple conditions is applied for, then it would be appropriate to list all the relevant ICD-10 codes.

4.3. I understand that panel members from the relevant advisory panel (representatives from the relevant professional body) will review the information I provide by completing this form as well as the motivation I attach. This information will form part of the final recommendation and funding decision as communicated to the patient on the completion of this application process.

4.4. We will not consider cover for both a chiropractor and physiotherapist for the same condition.

4.5. We will not consider cover for both a psychologist and a social worker for the same condition.

4.6. As a healthcare funder, Discovery Health Medical Scheme funds treatments related to medical or clinical needs. When a medical scheme member applies for funding for additional allied, therapeutic and psychology benefits after they reached their annual family limit for the year, it is important to note that the additional benefit does not include therapies related to disorders of a scholastic nature (educational), including but not limited to school readiness testing. The additional benefit for allied, therapeutic and psychology services is not designed to fund any conditions of a non-clinical or non-medical nature. If the therapy is clinically indicated, we will require supporting information for retrospective review.

5. Biokineticist section

Please note: Due to confidentiality, the patient's name is excluded, but please make sure that you include the patient's date of birth.

Membership number N N N N N N N N N

Patient age _____ Patient date of birth Y Y Y Y M M D D

Healthcare professional name and surname _____

BHF practice number N N N N N N N N N

Special interest _____

Telephone (W) _____ _____ Fax _____

Email _____

I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.

Signature of Healthcare professional _____ Date Y Y Y Y M M D D

5.1. Information about the patient's condition

5.1.1. Diagnosis details of current diagnosis

Please specify detailed ICD code(s)	Description	Date and nature of incident / onset	Duration	
			< 12 weeks	> 12 weeks

5.1.2. If your patient has a spine-related condition, please complete and attach the relevant Biokinetic spinal evaluation form which can be found on the Health Professional Zone at **www.discovery.co.za**

Condition		
Cervical spine	☐ Yes	☐ No
Lumbar spine	☐ Yes	☐ No

5.2. Information about the present treatment required referring to the above ICD 10 code

Consultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year to complete current diagnosis

Attach description to show what phase the member is currently in.

5.2.1. Number of sessions used

Year	Total amount of sessions (excluding additional benefit sessions)	Applied for additional benefit
2012		☐ Yes ☐ No
2013		☐ Yes ☐ No
2014		☐ Yes ☐ No
2015		☐ Yes ☐ No
2016		☐ Yes ☐ No
2017		☐ Yes ☐ No

Amount of additional funding sessions awarded in the previous benefit year: _____

Original start of therapy Y Y Y Y M M D D

Start date of therapy in current year Y Y Y Y M M D D

Last date of therapy in current year Y Y Y Y M M D D

Total number of sessions and frequency in current year: _____

5.2.2. Description of past treatment sessions to date, of above mentioned ICD 10 code (Please also indicate the procedure codes used)

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Biokineticist section (continued)

5.2.3. Motivation for treatment for above mentioned ICD 10 code (Include impact of treatment to date on functionality)

5.2.4. Goals for further treatment sessions

5.2.5. Relevant patient history (Include previous diagnoses, occupational and social functioning, previous treatment, hospitalisation, history of primary diagnosis)

6. Chiropractor section

Please note: Due to confidentiality, the patient's name is excluded, but please make sure that you include the patient's date of birth.

Membership number N N N N N N N N N

Patient age _____ Patient date of birth Y Y Y Y M M D D

Healthcare professional name and surname _____

BHF practice number N N N N N N N N N

Special interest _____

Telephone (W) _____ _____ Fax _____

Email _____

I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.

Signature of Healthcare professional _____ Date Y Y Y Y M M D D

6.1. Information about the patient's condition

6.1.1. Diagnosis details

Please specify detailed ICD code(s)	Description	Date and nature of incident / onset	Duration	
			< 12 weeks	> 12 weeks

6.2. Information about the present treatment required

Consultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year to complete current diagnosis

6.2.1. Number of sessions used

Year	Total amount of sessions (excluding additional benefit sessions)	Applied for additional benefit
2012		☐ Yes ☐ No
2013		☐ Yes ☐ No
2014		☐ Yes ☐ No
2015		☐ Yes ☐ No
2016		☐ Yes ☐ No
2017		☐ Yes ☐ No

Amount of additional funding sessions awarded in the previous benefit year: _____

Original start of therapy Y Y Y Y M M D D

Start date of therapy in current year Y Y Y Y M M D D

Last date of therapy in current year Y Y Y Y M M D D

Total number of sessions and frequency in current year: _____

6.2.2. Description of past treatment sessions to date (Please also indicate the procedure codes used)

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Chiropractor section (continued)

6.2.3. Motivation for treatment (Include impact of treatment to date on functionality)

6.2.4. Goals for further treatment sessions

6.2.5. Relevant patient history (Include previous diagnoses, occupational and social functioning, previous treatment, hospitalisation, history of primary diagnosis)

7. Occupational therapist section

Please note: Due to confidentiality, the patient's name is excluded, but please make sure that you include the patient's date of birth.

Membership number N N N N N N N N N

Patient age _____ Patient date of birth Y Y Y Y M M D D

Healthcare professional name and surname _____

BHF practice number N N N N N N N N N

Special interest _____

Telephone (W) _____ _____ Fax _____

Email _____

I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.

Signature of Healthcare professional _____ Date Y Y Y Y M M D D

7.1. Information about the patient's condition

7.1.1. Diagnosis details

Please specify detailed ICD code(s)	Description	Date and nature of incident / onset

7.2. Information about the treatment required

Consultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year to complete current diagnosis

7.2.1. Number of sessions used

Year	Total amount of sessions (excluding additional benefit sessions)	Applied for additional benefit
2012		☐ Yes ☐ No
2013		☐ Yes ☐ No
2014		☐ Yes ☐ No
2015		☐ Yes ☐ No
2016		☐ Yes ☐ No
2017		☐ Yes ☐ No

Amount of additional funding sessions awarded in the previous benefit year: _____

Original start of therapy Y Y Y Y M M D D

Start date of therapy in current year Y Y Y Y M M D D

Last date of therapy in current year Y Y Y Y M M D D

Total number of sessions and frequency in current year: _____

7.3. Brief summary of occupational therapy to date (Please also indicate the procedure codes used)

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7.4. Motivation for treatment (Include impact of treatment to date on functionality)

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Occupational therapist section (continued)

7.5. Detailed goals for further therapy

7.6. Brief history of patient's pre-morbid functioning and relevant patient history

7.7. **Motivation for treatment of adults – Please include additional motivation with this application including:**
Information about assistance required for participation in activities of daily living, functional transfers and upper limb function, cognitive and/or perceptual function, and pre-morbid work/school/university history.
Please note: Standardised tests and scores should be indicated in reports when formal testing was included in the assessment.

7.8. **Motivation for treatment of children – Please include additional motivation with this application including:**
Information about impact on development, behaviour, school and social functioning, as well as relevant birth and background history.
Please note: Standard scores should be indicated in reports when formal testing was included in the assessment.
Please include additional assessment and progress reports to this application for paediatric cases.

8. Physiotherapist section

Please note: Due to confidentiality, the patient's name is excluded, but please make sure that you include the patient's date of birth.

Membership number N N N N N N N N N

Patient age _____ Patient date of birth Y Y Y Y M M D D

Healthcare professional name and surname _____

BHF practice number N N N N N N N N N

Special interest _____

Telephone (W) _____ _____ Fax _____

Email _____

I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.

Signature of Healthcare professional _____ Date Y Y Y Y M M D D

8.1. Information about the patient's condition

8.1.1. Diagnosis details

Please specify detailed ICD code(s)	Description	Date and nature of incident / onset	Duration	
			< 12 weeks	> 12 weeks

8.2. Information about the treatment required

Consultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year to complete current diagnosis

8.2.1. Number of sessions used

Year	Total amount of sessions (excluding additional benefit sessions)	Applied for additional benefit
2012		☐ Yes ☐ No
2013		☐ Yes ☐ No
2014		☐ Yes ☐ No
2015		☐ Yes ☐ No
2016		☐ Yes ☐ No
2017		☐ Yes ☐ No

Amount of additional funding sessions awarded in the previous benefit year: _____

Original start of therapy Y Y Y Y M M D D

Start date of therapy in current year Y Y Y Y M M D D

Last date of therapy in current year Y Y Y Y M M D D

Total number of sessions and frequency in current year: _____

8.2.2. Description of past treatment sessions to date (Please also indicate the procedure codes used)

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Physiotherapist section (continued)

8.2.3. Motivation for treatment (Include outcome measures used and scores/impact of treatment to date on functionality)

8.2.4. Goals for further treatment sessions

8.2.5. Relevant patient history (Include previous diagnoses, occupational and social functioning, previous treatment, hospitalisation, birth history, milestones and history of primary diagnosis.)

9. Psychologist section

Please note: Due to confidentiality, the patient's name is excluded, but please make sure that you include the patient's date of birth.

Membership number N N N N N N N N N

Patient age _____ Patient date of birth Y Y Y Y M M D D

Healthcare professional name and surname _____

Tick the relevant box: Are you a ☐ Clinical psychologist ☐ Counselling psychologist ☐ Educational psychologist

BHF practice number N N N N N N N N N

Special interest _____

Telephone (W) _____ _____ Fax _____

Email _____

I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.

Signature of Healthcare professional _____ Date Y Y Y Y M M D D

9.1 Information about the patient's condition

9.1.1. Diagnosis details

Please specify detailed ICD code(s)	**Description**	**Date and nature of incident / onset**

9.1.2. Multi-axial diagnosis: Please give a DSM-V diagnosis

Current GAF and/or GARF	DSM-V
Pre-treatment GAF and/or GARF	

Additional/supporting comments about diagnosis, including impact on social and occupational/scholastic functioning (If a paediatric assessment has been done, please include/attach report recommendations):

9.1.3. Relevant patient history (Include previous diagnoses, occupational and social functioning, previous treatment, hospitalisation, history of primary diagnosis.) Please also indicate the procedure codes used.

9.1.3.1. Previous diagnosis

9.1.3.2. Current symptom presentations

9.1.3.3. Occupational and social functioning

Psychologist section (continued)

9.1.3.4. Previous treatment

9.1.3.5. Hospitalisation

9.1.3.6. History of primary diagnosis (including a description of stressors for trauma and stressor-related disorders)

9.1.4. Number of sessions used

Year	Total amount of sessions (excluding additional benefit sessions)	Applied for additional benefit
2012		☐ Yes ☐ No
2013		☐ Yes ☐ No
2014		☐ Yes ☐ No
2015		☐ Yes ☐ No
2016		☐ Yes ☐ No
2017		☐ Yes ☐ No

Amount of additional funding sessions awarded in the previous benefit year:

Original start of therapy Y Y Y Y M M D D

Start date of therapy in current year Y Y Y Y M M D D

Last date of therapy in current year Y Y Y Y M M D D

Total number of sessions and frequency in current year:

9.2. Information about the treatment required

Consultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year to complete current diagnosis

9.2.1. Indicate method(s) of treatment and treatment to date

Psychologist section (continued)

9.2.2. Treatment to date including additional sessions in the past three years (Indicate impact of treatment to date on social and occupational functioning. For children, include information about impact on development, behaviour, school and social functioning.)

9.2.3. Motivation for additional treatment

9.2.4. If you are treating multiple members of the same family, please motivate and give clear reasons, as this might pose an ethical consideration

10. Social Worker (additional mental healthcare benefits)

Confirm that you are a member of the Discovery Health Social Worker in Mental Health Network, before completing the below section. Please note: Due to confidentiality, the patient's name is excluded, but please make sure that you include the patient's date of birth.

Membership number N N N N N N N N N

Patient age _____ Patient date of birth Y Y Y Y M M D D

Healthcare professional name and surname _____

BHF practice number N N N N N N N N N

Special interest _____

Telephone (W) _____ _____ Fax _____

Email _____

I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.

Signature of Healthcare professional _____ Date Y Y Y Y M M D D

10.1. Information about the patient's condition

10.1.1. Diagnosis details

Please specify detailed ICD code(s)	**Description**	**Date and nature of incident / onset**

10.1.2. Multi-axial diagnosis: Please give a DSM-V diagnosis

Current GAF and/or GARF	DSM-V
Pre-treatment GAF and/or GARF	

Additional/supporting comments about diagnosis, including impact on social and occupational/scholastic functioning:

10.1.3. Relevant patient history

(Include previous diagnoses, occupational and social functioning, previous treatment, hospitalisation, history of primary diagnosis) Please also indicate the procedure codes used.

10.1.4. Number of sessions used

Year	**Total amount of sessions (excluding additional benefit sessions)**	**Applied for additional benefit**
2012		☐ Yes ☐ No
2013		☐ Yes ☐ No
2014		☐ Yes ☐ No
2015		☐ Yes ☐ No
2016		☐ Yes ☐ No
2017		☐ Yes ☐ No

Amount of additional funding sessions awarded in the previous benefit year: _____

Original start of therapy Y Y Y Y M M D D

Start date of therapy in current year Y Y Y Y M M D D

Last date of therapy in current year Y Y Y Y M M D D

Total number of sessions and frequency in current year: _____

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Social Worker (additional mental healthcare benefits) (continued)

10.2. Information about the treatment required

Consultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year to complete current diagnosis

10.2.1. Indicate method(s) of treatment and treatment to date

10.2.2. Treatment to date including additional sessions in the past three years
(Indicate impact of treatment to date on social and occupational functioning. For children, include information about impact on development, behaviour, school and social functioning.)

10.2.3. Motivation for additional treatment

11. Speech-language therapist and audiologist section

Please note: Due to confidentiality, the patient's name is excluded, but please make sure that you include the patient's date of birth.

Membership number N N N N N N N N N

Patient age _____ Patient date of birth Y Y Y Y M M D D

Healthcare professional name and surname _____

BHF practice number N N N N N N N N N

Special interest _____

Telephone (W) _____ _____ Fax _____

Email _____

I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.

Signature of Healthcare professional _____ Date Y Y Y Y M M D D

This application should be supported by a comprehensive report.

11.1. Information about the patient's condition

11.1.1. Diagnosis details

Please specify detailed ICD code(s)	Description	Date and nature of incident / onset

11.2. Information about the treatment required

Consultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year to complete current diagnosis

11.2.1. Number of sessions used

Year	Total amount of sessions (excluding additional benefit sessions)	Applied for additional benefit
2012		☐ Yes ☐ No
2013		☐ Yes ☐ No
2014		☐ Yes ☐ No
2015		☐ Yes ☐ No
2016		☐ Yes ☐ No
2017		☐ Yes ☐ No

Amount of additional funding sessions awarded in the previous benefit year: _____

Original start of therapy Y Y Y Y M M D D

Start date of therapy in current year Y Y Y Y M M D D

Last date of therapy in current year Y Y Y Y M M D D

Total number of sessions and frequency in current year: _____

11.2.2. Description of past treatment sessions to date (Please also indicate the procedure codes used)

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Speech-language therapist and audiologist section (continued)

11.2.3. Motivation for treatment
(Indicate impact of treatment to date on functionality)

11.2.4. Goals of further treatment sessions

11.2.5. Relevant patient history
(Include previous diagnoses, occupational and social functioning, previous treatment, hospitalisation etc.
For children please include the child's birth history, milestones and history of primary diagnosis)
Please include additional assessment and progress reports to this application for paediatric cases