



Prescribed Minimum Benefits (PMB) Chronic Disease List (CDL) application form

Contact us

Tel: 0860 100 693, PO Box 652509, Benmore, 2010, www.avgms.co.za

Please complete this form if you want to apply for extra cover for the diagnosis of, medicine for, or out-of-hospital management of a Prescribed Minimum Benefit (PMB) condition

How to complete this form

- Please use one letter per block, complete with black ink and print clearly.
- Fax the completed and signed form to **011 539 7000** or post it to Anglovaal Group Medical Scheme, Chronic Illness Benefit, PO Box 652509, Benmore, 2010.
- As a member, please complete section 1 of this form.
- Your doctor must complete section 2 and 3, and include detailed documents supporting your application.

You will receive a letter	informing	you of	f our d	ecision	and the	e prod	cess	to k	oe fo	ollov	ved	for	appro	veo	d req	ues	ts.														
1. About the patient (member to complete if patient is a minor)																															
Title Ir	nitials			Sı	ırname																										
First name																															
ID number																				Da	te c	of bi	rth	Υ	Υ	Υ	Υ	M	M	D	D
Membership number																															
Postal address																															
																										Co	ode				
Telephone (H)																	(V	V) [
Cellphone																	Fa	ax [
Email address																															
Name of patient (if a minor)																															
May we communicate your	confident	tial info	ormatio	on to yo	ou at th	is en	nail	add	ress	?	,	Yes		No			or	fax	nuı	mbe	r '	Yes		No) []					
Has your condition been app	proved o	n the C	hronic	Illness	Benefi	t?					,	Yes		No																	
If yes , your doctor must list the condition for which you are approved below.																															
Patient's signature (if patient is a minor, main member to sign) Date				Υ	Υ	Υ	M	M	D I	D																					
2. Application (docto	or to co	omple	te)																												
2.1 Application for out-	of-hospi	ital m	edical	mana	gemer	nt																									
Condition Consultation or procedure code				M	Motivation and number of extra consultations or procedures																										
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2. Application (doctor to complete) (continued)

2.2	aaA	lication	for	medicine
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Request for current medicine (please provide details and relevant laboratory tests to show success of therapy example blood pressure reading or HBA1C)

Condition	Medicine name, strength and dosage	Quantity each month	Is the patient controlled? (Please attach relevant details)		
2.3 Previous medicine history					

Medicine	Date medicine started	Length of therapy	Side effects experienced*	Lack of efficacy**

^{*} Please provide details and severity

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3. Doctor's details (doctor to complete)								
Name of doctor								
Practice number	Speciality Speciality							
Fax								
Email								
Date	2 0 Y Y M M D D							
Doctor's signature								
The outcome of this application must be communicated to me through my email address Yes No or fax number Yes No								

^{**} Please provide details and attach laboratory test where appropriate