GEMS PMB Request Form

Out of Hospital

Government Employees Medical Scheme

Important to note: This form is not for oncology treatement or chronic medicine.

Chronic medicine: to be authorised via the Chronic Medicine process: Tel: 0860 004 367 (member and provider) Fax: 0861 004 367.
Oncology management: register member by submitting proposed treatment plan by fax 0861 004 367 or email enquiries@gems.gov.za.
Attach all relevant special investigations and lab results to this form when submitting.
Submit form via fax 0861 004 367 or email; enquiries@gems.gov.za.

Indicate purpose of form:
Please tick appropriate box and fill in relevant sections

- ☐ **New Treatment Plan** (A, B, D, E)
- ☐ **Motivation for extra treatment** (A, B, D, E)
- ☐ **Motivation for waive rules on non-DSP usage** (A-D)

Section A: Membership Details

Patient Details

Surname: _____ First name: _____

Member number: ☐☐☐☐☐☐☐☐☐☐ Dependant code: ☐☐ Option/Plan: _____

Date of birth: ☐☐☐☐☐☐☐☐ ID Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐

Daytime Contacts details: Tel: _____ Email: _____

Section B: Treatment Healthcare Provider Details

Details of the doctor who will be providing the ongoing care

Surname: _____ Initials: _____

Practice number: ☐☐☐☐☐☐☐☐☐☐ Speciality: _____

Tel: _____ Fax: _____

Cell: _____ Email: _____

Section C: Motivation to Waive Rules on Non-DSP

A DSP is a healthcare provider or group of providers who have been selected by the Scheme to deliver the diagnosis, treatment and care in respect of PMB conditions to its members. If you choose to use a healthcare provider other than the DSP for the treatment of a PMB condition, the Scheme may impose a co-payment or limit the rate at which claims are reimbursed. The application to waive the non-DSP override will not be considered unless sufficient proof is provided that treatment at the DSP could not be reasonably accessed.

Please select one of the reasons for the waiver request below.

- ☐ **New Treatment Plan** (A, B, D, E)
- ☐ **Motivation for extra treatment** (A, B, D, E)
- ☐ **Motivation for waive rules on non-DSP usage** (A-D)

Section D: Patient Consent

• I understand that all personal clinical information supplied to the GEMS PMB Programme will be used to determine access to specific benefits for PMB conditions. The programme's medical staff will review this information in order to make recommendations regarding the provision of these benefits. My/my dependant/s healthcare provider, however, retains responsibility for my/my dependant/s care, irrespective of the benefits so authorised.
• I/we therefore, authorise any healthcare provider, hospital, clinic, laboratory and/or medical facility in possession of any medical information regarding myself (the applicant) or any dependant (including newborn baby), to provide the GEMS PMB Programme with information that it may require. I warrant that the information in this application form is correct. I acknowledge that I will be responsible for any co-payments as per Scheme rules or payment for any medication and/or investigations not authorised by the GEMS PMB team.
• I understand and agree that medical information relevant to my current state of health can be used for the purpose of scientific, epidemiological and/or financial analysis without disclosure of my identity. I acknowledge that benefits authorised by the GEMS PMB Programme are subject to managed care guidelines. I am aware that more information on the PMBs can be obtained from the Scheme and the Council for Medical Schemes (CMS).

Patient's Signature _____ Date: D D M M Y Y Y Y

Name and surname: _____

Section E: Full Treatment Plan

Details to be completed by treating healthcare provider.
*Procedure or Consultation; nappi code for acute medicine; etc.

ICD-10	PMB Condition	*Code	Description	No. per year	Motivation
eg: I10	Hypertension	0190	Consultation	3	BP 160

Doctor's Signature _____ Date: D D M M Y Y Y Y

Name and surname: _____