Application for in-hospital Prescribed Minimum Benefit (PMB)

Funding for non-network healthcare providers

gems
Government Employees Medical Scheme

Important to note: This form is for retrospective PMB claims for non-network healthcare providers.

How to use this form:

Please complete all relevant sections and email the completed form with the supporting documentation to **enquiries@gems.gov.za or fax to 0861 00 4367.**

Purpose of this form:

This form is to apply for an in-hospital related claim to be reviewed for payment as a Prescribed Minimum Benefit (PMB).

A medical emergency is defined in the Medical Scheme's Act as the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy.

Urgent or unplanned events are not automatically classified as an emergency.

Only complete this form if your query meets ALL the criteria below.
☐ You are not contracted to the GEMS network.
☐ Your PMB claim has previously been submitted and was short paid to Scheme rates.
☐ The PMB claim was incurred in hospital.

Section A: Patient details

Membership No. Benefit Option

Patient Name

Patient Surname

Dependant Code Patient ID No.

Section B: Provider details

Practice No.

Patient Name

Discipline

Contact No.

Email address

Section C: Reason for enquiry

Service date		ICD-10 code	PMB code description	Tariff code	Tariff code description	Hospital auth. number	Fees charged	Benefit paid
From	To							

Diagnosis at admission:

Final diagnosis:

Section D: Supporting information

Please provide clinical information relating to the symptoms that the patient presented with, clinical findings including vital signs at admission and during the hospital event, pathology reports, radiology reports and treatment provided. In the event of an obstetric emergency, the partogram/nursing notes and CTG may be required.

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

Name and surname _____