

CONSULTATION AND TREATMENT CODES APPLIED FOR:

NB: List all consultation, radiology, pathology and other treatment codes

Tariff code	Description	Quantity per month	Number of repeats required	Start date of requested authorisation

Patient Name

Surname

Member number

SECTION D: ACUTE OR EVENT SPECIFIC PMB SERVICES

Service date	Tariff code	Tariff charged	Service date	Tariff code	Tariff charged

Confirm billing practice / tariff structure of the practice applying for funding at cost.

Was the patient and / or member / family informed of the fees to be charged?

YES	NO
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- If YES, please provide a copy of the signed document/consent.
- If NO, please motivate

SECTION E: MOTIVATION

Please attach copies of blood test results and / or any other relevant diagnostic reports.

SECTION F: DETAILS OF DOCTOR APPLYING FOR BENEFITS

Initials

Surname

Practice number

Speciality

Tel (W)

Fax

Signature of doctor: _____

Date: _____

SECTION G: PATIENT CONSENT

I, _____ (member) acknowledge that I am aware of the tariff structure of the practice, as well as the Bestmed funding guideline for approved services at the Bestmed rate. I choose to make use of this provider

I hereby give permission to the doctor or any other service provider to state the diagnosis and mention any other information relating to my condition(s) on the form. I understand that this information will remain confidential at all times.

Signature of member: _____

Date: _____