HIV Prescribed Minimum Benefits (PMB) application form
Request for additional cover from Prescribed Minimum Benefits

Who we are

Bankmed (referred to as 'the Scheme'), registration number 1279, is a not-for-profit organisation, registered with the Council for Medical Schemes. Discovery Health (Pty) Ltd (referred to as 'the Administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07) which takes care of the administration of your membership for the Scheme.

How to complete this form

1. To avoid administration delays, kindly ensure this application is completed in full
2. Kindly complete this form should you wish to apply for additional cover for the diagnosis of, medication for, or out-of-hospital management of a HIV PMB condition
3. You (the member) are required to complete sections 1 and 2 of this form
4. Your Healthcare Professional is required to complete sections 3 and section 4, and include detailed documentation supporting your application
5. Kindly send this completed and signed form with any supporting documentation by e-mail to **hiv@bankmed.co.za**, or post it to **Bankmed Medical Scheme, Private Bag X2, Rivonia 2128**. You may also contact our **Call Centre on 0800 BANKMED (0800 226 5633)** should you have any questions
6. A dedicated case manager will contact both you and your treating Healthcare Professional to inform you about our funding decision and the process to follow should your application be approved

1. Principal Member's details

Membership number	
ID or passport number	
Member's surname	
Member's name	

2. Patient details

Title	Initial(s)
Surname	
First name(s)	
ID or passport number	Membership number
Telephone (H)	Telephone (W)
Cellphone	
E-mail	
Relationship to Principal Member	
Patient's signature	Date D D M M Y Y Y Y

(if patient is a minor, Principal Member to sign)

Please note that this form expires on 31/03/2027. Up to date forms are available on www.bankmed.co.za.

Bankmed Medical Scheme. Registration number 1279.

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Page 1 of 2
01.01.2026

3. Information about treatment request (Healthcare Professional to complete)

3.1. Application for medical management

Out-of-hospital ☐

Condition	RPL consultation or procedure code	RPL description	Number of consultations or procedures per year

3.2. Application for medication

Current medication requested *(please provide details)*

Condition	Medication name, strength and dosage	NAPPI code	Frequency

3.3. Application for radiology

Condition	Code	Description	Quantity

3.4. Application for pathology

Condition	Code	Description	Quantity

4. Healthcare Professional's details *(Healthcare Professional to complete)*

Name

BHF practice number   Speciality

Telephone number

E-mail

Healthcare Professional's signature   Date D D M M Y Y Y Y

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