Request for additional cover for Chronic Disease List (CDL) conditions registered on the Chronic Illness Benefit (CIB) 2025

Who we are

Discovery Health Medical Scheme, registration number 1125, is a not-for-profit organisation registered with the Council for Medical Schemes, and is the medical scheme that you are a member of.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Discovery Health Medical Scheme and takes care of the administration of your membership.

Contact us

Tel (members): **0860 99 88 77**, Tel (health partners): **0860 44 55 66**, **www.discovery.co.za**, PO Box 784262, Sandton, 2146
1 Discovery Place, Sandton, 2196

Purpose of the form

This application form is to apply for additional cover for Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions registered on the Chronic Illness Benefit (CIB) and is only valid for 2025.

What you must do

- Fill in the form in black ink and print clearly or complete the form digitally. You can view the list of approved digital signature providers on **www.discovery.co.za**, under Medical Aid > Find documents and certificates > Application forms.
- All relevant sections must be physically signed by the doctor and cannot be signed digitally. The doctor must sign and date any changes.
- Email the completed and signed form to **CIB_APP_FORMS@discovery.co.za,** or get help on **www.discovery.co.za**, under Medical Aid > Get Help > Submit a document and follow the guided steps through our Virtual Agent.
- To avoid administrative delays, please ensure this form is completed in full by you and your doctor.
- There is overwhelming medical evidence that patients experience improved health outcomes when their primary care is coordinated through a single primary care GP. In line with this best practice, for all plans except the Executive Plan, you and your dependants need to nominate a primary care GP for the effective management of your chronic conditions. When you visit your nominated network GP for the management of your chronic condition, we'll cover the consultation in full. If you see a GP who is not your nominated primary care GP, or your nominated GP is not a network GP, you will be responsible for any co-payments. You and your dependants can change your nomination three times every calendar year. Nominate your GP or manage your existing nomination on **www.discovery.co.za** > Medical aid > Nominate a primary care GP.

1. Patient details (main member to complete on behalf of the patient if patient is a minor)

Title | Initials
First name(s)
Surname
Membership number | ID or passport number
Telephone (H) | Telephone (W)
Cellphone | Email

The outcome of this application will be sent to you by email.

2. Request for additional consultations and procedures (doctor to complete)

Your patient has automatic access to an annual treatment basket containing a limited number of consultations and procedures when approved for a Chronic Disease List (CDL) condition. Please complete the table below where the request is for further cover or for consultations or procedures not included in the treatment basket.

Condition	Consultation or procedure code	Number of consultations or procedures required per year	Supporting information for the request

Please note that this form expires on 31/03/2026. Updated forms are always available at www.discovery.co.za under **Medical Aid** > **Find documents and certificates**.

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3. Request for cover in full for non-formulary medicine

Please complete the table below where non-formulary medicine is prescribed for the treatment of Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions and the request is for cover without co-payment. Please supply additional information and supporting documentation where appropriate, as to why the formulary medicine cannot be used by the patient, including details of treatment failure or adverse drug reactions where applicable.

Medicine name and strength	Quantity	Supporting information for the request

Previous medicine history

Medicine name and strength	Date treatment with this medicine was initiated	How long did the patient use the medicine for?	Details of treatment failures or adverse drug reactions

4. Doctor's details (doctor to complete)

First name(s)

Surname

BHF practice number

Speciality

Telephone

Email

The outcome of this application will be communicated to you by email.

Signature of doctor

Date D D M M Y Y Y Y

Please only sign if information is true, complete and correct.