ANGLOVAAL
GROUP MEDICAL SCHEME

Administered by Discovery Health

Contact details
Tel: 0860 100 693 • PO Box 652509, Benmore 2010 • www.avgms.co.za

HIV PMB application form

Request for additional cover from the Prescribed Minimum Benefits

Who we are
The Angloval Group Medical Scheme (referred to as 'the Scheme'), registration number 1571. This is a non-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 number1997/013480/07). We take care of the administration of your membership for the Scheme.

Patient Name and surname

Membership number

How to complete this form
1. Please use one letter per block, complete in black ink and print clearly.
2. Please complete this form if you wish to apply for additional cover for the diagnosis of, medicine for, or out-of-hospital management of a Prescribed Minimum Benefit (PMB) condition.
3. You (the member) must complete Section 1 of this form.
4. Your doctor must complete Section 2 and Section 3, and include detailed documents supporting your application.
5. Please email this completed and signed form with any support documentation to **HIV_Diseasemanagement@avgms.co.za** or fax it to 011 539 3151 or post it to **Anglovaal Group Medical Scheme, PO Box 536, Rivonia, 2128.**
6. A dedicated case manager will call you and your treating doctor to let you know about our funding decision and the process to follow if your application is approved.
7. You can also contact our call centre on **0860 100 693** if you have any questions.
8. To avoid administration delays, please ensure this application is completed in full.

1. Main member details

Membership number

ID or passport number

Member's name

Member's surname

2. Patient details

Title Initial(s)

First name(s)

Surname

Membership number

ID or passport number

Telephone (H) Telephone (W)

Cellphone

Email

Relationship to main member

Patient's signature Date D D M M Y Y Y Y

(if patient is a minor, main member to sign)

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Please note that this form expires on 31/03/2025. Up to date forms are available on www.avgms.co.za.

3. Information about treatment request *(doctor to complete)*

3.1. Application for out-of-hospital medical management

Condition	Consultation and procedure code	Motivation and number of extra medicines and dosages

3.2. Application for medicine

Request for the current medicine (please provide details and relevant laboratory tests to show indication for therapy)

Condition	Medicine name, strength and dosage	Motivation and number of extra medicines and dosages

3.3. Previous medicine history

Medicine	Date medicine started	Length of therapy	Side effects experienced*	Lack of efficacy**

** Please provide details and severity.*
*** Please provide details and attach laboratory tests where applicable.*

Doctor's details *(doctor to complete)*

Name

Practice number | Telephone (H)

Email

Doctor's signature | Date D D M M Y Y Y Y