sasolmed

Contact details
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Request for additional cover for Chronic Disease List conditions on the Chronic Illness Benefit 2024

Who we are

Sasolmed (referred to as 'the Scheme'), registration 1234, 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 number 1997/013480/07). Discovery Health takes care of the administration of your membership for the Scheme.

Purpose of the form

This application form is to apply for additional cover for Chronic Disease List (CDL) conditions available on the Chronic Illness Benefit and is only valid for 2024.

What you must do

- Fill in the form in black ink and print clearly, or complete the form digitally.
- All relevant sections must be signed by the healthcare provider physically or digitally. The healthcare provider must sign and date any changes.
- Email the completed and signed form to **CIB.appeal@sasolmed.co.za**.
- Ensure this form is completed in full by you and your healthcare provider.

1. Patient details

Title ____ Initials ____ Surname ____

First name(s) ____

Membership number ____

ID or passport number ____

Telephone (H) ____ Telephone (W) ____

Cellphone ____

Email ____

Relationship to principal member ____

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

Your patient has automatic access to an annual treatment basket containing a limited number of consultations and procedures when approved for a Prescribed Minimum Benefit (PMB) 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 additional consultations or procedures required per year	Supporting information for the request

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

3. Healthcare provider’s details (healthcare provider 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 healthcare provider

Date D D M M Y Y Y Y