UMVUZO HEALTH

rx health

www.umvuzohealth.co.za

Alenti Office Park, Building D, 457 Witherite Road, The Willows, Pretoria, 0040.
P.0 Box 1463, Faerie Glen, 0043. **T:** +27 (0) 86 108 3084 **E:** info@umvuzohealth.co.za

YANDISA BENEFIT APPLICATION FORM

Kindly ensure that the form is signed and contains all the required information. Forward it together with the results of relevant special investigations to appeal@rxhealth.co.za.

Please note: All fields must be completed for your application to be considered. Incomplete forms will be discarded.

1. PATIENT DETAILS (ALL FIELDS ARE MANDATORY)

Patient name and surname	

Patient Gender		Male		Female	Patient Date of birth	Y	Y	Y	Y	M	M	D	D

If the patient is not the main member, please list the name and surname of the main member.

Name		Surname	
Option		Membership number	
Join date	YYYYMMDD	Employer Group	

Cellphone number where the main member can be contacted	
Additional contact number	
E-mail address, if available	

2. ACKNOWLEDGEMENT BY MAIN MEMBER

I ______________________________ (full name and surname) hereby declare that:

1. **All information supplied** on this application form is, to the best of my knowledge and belief, true, correct and complete, and that I will advise the Scheme as soon as any of the information changes.
2. **I have read** the Privacy Policy of Umvuzo Health Medical Scheme and confirm that I fully understand my/our rights in respect of my/our personal information processed by the Scheme, how the Scheme will process my/our information and with whom it will be shared.
3. **I understand** that the application for the Yandisa Benefit, does not constitute a guarantee of authorisation. The final decision resides with the Scheme's Clinical Committee.
4. **I provide** the consent below out of my own free will without any undue influence from any person whatsoever.
5. **I have familiarised** myself with the rules, benefits and networks of the Scheme and subject myself to them.
6. **I grant permission** to any healthcare provider, person or party who may be in possession of information concerning my health or that of my dependants, to divulge such information to Umvuzo Health or its duly contracted agents upon request, also after my death.

____

Signature of applicant (main member)

Date	Y	Y	Y	Y	M	M	D	D

3. TREATING HEALTHCARE PROVIDER DETAILS

Section 3 - 10 to be completed by the treating Healthcare Provider.

Full name and surname	
Discipline	
PR number	
Contact number	
E-mail address	
Practice physical address	

4. CLINICAL CONDITION AND BACKGROUND RELATED TO THE CHALLENGES THAT PROMPTED THIS BENEFIT REQUEST:

History (when it started, what happened and current treatment):

Current clinical problems and specific challenges why the item(s) is requested:

5. ITEM(S) REQUESTED

No.	Description	Rand amount

6. EXCEPTIONAL CIRCUMSTANCES

Please elaborate why the items listed above should be considered for funding from the Yandisa Benefit. Include what other items were utilised and what the results of their use were. Also, include any patient-specific factors.

The requested items are required because:

Other items tried and their outcomes:

Patient-specific factors that need to be considered:

7. CURRENT TREATMENT AND ENVISAGED TREATMENT PLAN

Please elaborate how the specific challenges outlined under (4) above, will be impacted by the requested item(s) and how the item(s) is foreseen to change the outcome of the treatment plan.

8. FUNCTIONAL NEED

When an item is considered for funding from the Yandisa Benefit, the item(s) must have a specific role and function that will contribute to the patient's care, daily life and health. Please elaborate how this item(s) will affect, enhance or impact the patient's functionality.

9. FINANCIAL MOTIVATION

Please give details on the financial reasons for this request.

Patient's financial factors:	

Please explain how the funding of this item is expected to impact future funding or costs incurred by Umvuzo Health.

10. ADDITIONAL INFORMATION OR MOTIVATION

Please add any additional information or motivation not listed under any of the above.

Please attach all relevant reports, results and quotations when sending your application form to appeal@rxhealth.co.za

Signature of Healthcare Provider

Date	Y	Y	Y	Y	M	M	D	D