

PATHFINDER: APPEALS APPLICATION: MEDICAL BENEFITS

How to lodge an appeal:

- Please complete and sign the form fully, attach relevant medical information and report to:
 PATHFINDER Appeals Committee
 Private Bag x128
 CENTURION
 0046
- Section A to be completed by patient
- Section B to be completed by service provider (e.g. medical practitioner, specialist, dentist)

SECTION A

Patient particulars:

Fund name		Membership no.	
Option			
First names			
Surname		Provider/Doctor	

Benefits originally applied for (tick appropriate):

- | | |
|--------------------------|-----------------------------|
| <input type="checkbox"/> | Chronic medication benefits |
| <input type="checkbox"/> | Disease management benefits |
| <input type="checkbox"/> | Hospitalization benefits |
| <input type="checkbox"/> | Dental benefits |

I understand and accept that personal clinical information will be made available to my medical scheme and their authorized agents by my medical practitioner in order to assess the appeals application. I understand that the information will remain confidential at all times.

I declare that the information provided is correct.

Signature of patient
(when patient is older than 14 years)

Signature of principal member
(when patient is younger than 14 years)

Date

SECTION B

Please indicate which specific service/medication/procedure was requested:

If medication, please supply all relevant information (diagnosis and clinical motivation)

Please motivate why this decision should be reconsidered:

Did you attach any additional information/reports/motivations (tick appropriate):

Yes

No

Particulars of medical practitioner

Name of practitioner			
Address			Area code
SAMDC number	Tel (code)		
Practice number	Fax (code)		
Date	Qualifications		
	Signature		