



Medical scheme

PSYCHIATRIC APPLICATION FORM

OUTPATIENT MENTAL HEALTH BENEFITS

For out-of-hospital psychotherapy sessions in lieu of hospitalisation, we require the treating physician to kindly complete this form and return it to the details provided at the end of this form.

PLEASE USE BLOCK LETTERS FOR ALL SECTIONS

*Compulsory fields

1. MEMBER AND PATIENT INFORMATION

MAIN MEMBER DETAILS

Membership number	<input type="text"/>	Benefit option	<input type="text"/>
Title	<input type="text"/>	Initials	<input type="text"/>
		ID number*	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Full name and surname	<input type="text"/>		
Email address	<input type="text"/>		

PATIENT DETAILS

Dependant code	<input type="text"/>
Title	<input type="text"/>
	Initials <input type="text"/>
	ID number* <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Full name and surname	<input type="text"/>
Contact numbers	<input type="text"/>
	Home <input type="text"/>
	Work <input type="text"/>
	Cell phone <input type="text"/>
Postal address	<input type="text"/>
	<input type="text"/>
	Postal code <input type="text"/>
Email address	<input type="text"/>

2. MEDICAL PRACTITIONER'S INFORMATION

DOCTOR DETAILS

Practice number	<input type="text"/>
Initials	<input type="text"/>
	Speciality <input type="text"/>
Surname	<input type="text"/>
Contact numbers	<input type="text"/>
	Work <input type="text"/>
	Fax number <input type="text"/>
	Cell phone <input type="text"/>
Postal address	<input type="text"/>
	<input type="text"/>
	Postal code <input type="text"/>
Email address	<input type="text"/>

Membership number	<input type="text"/>	Doctor's practice number	<input type="text"/>
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3. CLINICAL INFORMATION

Date of diagnosis

D	D	M	M	Y	Y	Y	Y
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ICD-10 code(s)

Consultation/procedure code(s)	Quantity requested

CURRENT MEDICATION

CLINICAL INDICATION/MOTIVATION

Referring doctor's signature

Date

D	D	M	M	Y	Y	Y	Y
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Membership number

Doctor's practice number

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MENTAL HEALTH PROGRAMME

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