De Beers Benefit Society
Prescribed Minimum Benefit (PMB) Application Form

PLEASE COMPLETE AND E-MAIL TO benefitpost@dbbs.co.za

Membership Detail	
Medical Aid number	
Patient Name	
ID Number	
Dependent Code	

Provider Information	
Practice number	
Contact Detail *(telephone number, fax number, e-mail address)*	

PMB Request Information	
Service date	
Hospital practice number (*if applicable*)	
Nature and severity of condition or injury?	
Procedure Codes BHF/CPT	
Co-morbidities	
Final/Discharge Diagnosis Code (ICD-10)	
PMB Code	
Drug used	
Response to previous therapy(*if applicable*)	
Other information deemed necessary *(Please attach supporting documentation to this document if applicable)*	

De Beers Benefit Society
Prescribed Minimum Benefit (PMB) Application Form

FOR OFFICE USE

DSP	YES	NO
Voluntary or Involuntary Admission/treatment	VOLUNTARY	INVOLUNTARY
DTP (Diagnosis and Treatment Pair)	YES	NO
PMB Benefit Approved	YES	NO
Date		
Signature		
Designation/Department		