Application for additional services during an in-hospital admission for depression 2026

Contact details
Tel: 0860 116 116 • PO Box 652509, Benmore 2010 • www.yourremedi.co.za

Who we are

Remedi Medical Aid Scheme (referred to as 'the Scheme'), registration number 1430, is a not-for-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 (Pty) Ltd administers Remedi Medical Aid Scheme.

Contact us

Tel (Members): **0860 116 116 |** Tel (Health Partners): **0860 44 55 66** Website: **www.yourremedi.co.za** | Address: PO Box 652509, Benmore, 2010 | 1 Discovery Place, Sandton, 2196

What you must do

- Fill in the form in black ink and print clearly.
- All relevant sections must be completed.
- You can email the signed form with any supporting documentation to **psychmanagement@discovery.co.za** as an addendum to the PsychMG form, where applicable.
- You will receive an email informing you of our decision and the process you should follow.

1. Important patient information

Title | Initials

Surname

First name(s)

ID or passport number | Membership number

Authorisation number

Cellphone

Email

2. Request for additional services

Please note that all fields below are mandatory and the professional billing codes must be supplied for us to review the application.

ICD-10 code	Consultation or procedure code**	Consultation or procedure description	Quantity required	Motivation

All additional services requested are limited to the admission during which this form is submitted

3. Healthcare provider's details (healthcare provider to complete)

Name and surname

BHF practice number

Telephone

Email

Notes to healthcare provider

3.1. Please ensure that the relevant ICD-10 code(s) is used when you submit your claims to the Scheme to ensure payment from the correct benefit.

3.2. Please include the ICD-10 code(s) when referring your patient to the pathologists and/or radiologists. This will enable the pathologists and radiologists to include this information on their claims and allow us to pay claims correctly.

3.3. Please submit all the requested supporting documents with this application to prevent delays in the review process.

Healthcare provider's signature

Date D D M M Y Y Y Y

Please only sign if information is true, complete and correct