

# Disputes investigation form 2024 (application to investigate a Dispute)

## Who we are

Discovery Health Medical Scheme, registration number 1125, is a not-for-profit organisation registered with the Council for Medical Schemes, and is the medical scheme that you are a member of.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Discovery Health Medical Scheme and takes care of the administration of your membership.

## Contact us

Tel (members): **0860 99 88 77**, Tel (health partners): **0860 44 55 66**, [www.discovery.co.za](http://www.discovery.co.za), PO Box 784262, Sandton, 2146, 1 Discovery Place, Sandton, 2196.

## Purpose of the form

If you have escalated your complaints through the relevant channels and are still unsatisfied with the outcome, you have the option of either lodging a dispute by completing and sending this form to the Discovery Health Medical Scheme, as below or lodging a complaint with the Council for Medical Schemes (CMS).

## What you must do

Please go through these steps:

- Familiarise yourself with the disputes investigation process below.
- Fill in the form in black ink and print clearly or complete the form digitally. You can view the list of approved digital signature providers on [www.discovery.co.za](http://www.discovery.co.za), under Medical Aid > Find documents and certificates > Application forms.
- All relevant sections must be signed by the main member. The main member must sign and date any changes.
- Please return the completed and signed form to the Benefit Compliance Review department. The form may be received through any of the below avenues:
  - You can email it to [mydispute@discovery.co.za](mailto:mydispute@discovery.co.za) or
  - You can submit the form on [www.discovery.co.za](http://www.discovery.co.za) under Medical Aid > Get Help > Submit a document and follow the guided steps through our Virtual Agent, or
  - You can post the form to P.O. Box 786722, Sandton, 2146. Please ensure that the form is in a marked envelope addressed to the Benefit Compliance Review department.

## Important information to note

The CMS can be contacted via email: [complaints@medicalschemes.co.za](mailto:complaints@medicalschemes.co.za)/ Customer care centre: **0861 123 267** or website: [www.medicalschemes.co.za](http://www.medicalschemes.co.za). You can view and read our Privacy Statement on [www.discovery.co.za](http://www.discovery.co.za) > Medical aid > [About Discovery Health Medical Scheme](#).

## 1. Dispute investigation process

### 1. Purpose of lodging a Dispute

If you have escalated your complaints through the relevant channels through the administrator and are still unsatisfied with the outcome, or if you feel that the Scheme has not abided by its registered Rules or the provisions of the Medical Schemes Act, then you may lodge a dispute in terms of Scheme Rule 27.

By completing this form, you are initiating an investigation of your complaint. Upon receipt of this completed form, we will investigate the matter and provide you with a written outcome of the investigation.

### 2. Duration to investigate and respond to the dispute

While we endeavour to provide you with a response as soon as possible, the registered Rules makes provision for 30 days. Should we require a longer period to investigate and respond to your dispute, we will let you know.

### 3. Recourse of the Dispute investigation outcome

If you are not satisfied with the outcome of the investigation, you may then request that a Disputes Committee Hearing be scheduled in response to the outcome of the investigation.

### 4. Contact the Council for Medical Schemes ("CMS")

You may contact the Council for Medical Schemes at any stage of the complaints process but are encouraged to follow the internal Scheme process as described above to resolve your complaint before contacting the Council for Medical Schemes directly. Members who wish to approach the Council for Medical Schemes directly for assistance, may do so in writing to: Council for Medical Schemes Complaints Unit, Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157 or email [complaints@medicalschemes.co.za](mailto:complaints@medicalschemes.co.za). Customer care centre: **0861 123 267**/or website [www.medicalschemes.co.za](http://www.medicalschemes.co.za)



#### 4. Consent by member to outside representation

I, <input type="text"/>	ID or passport 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"/>
hereby give consent to <input type="text"/>	ID or passport 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"/>

to represent me in this complaint and any hearing that may arise from this complaint. I also agree to Discovery Health Medical Scheme collecting and collating my relevant Personal Information from other relevant sources, including medical practitioners, contracted service providers, financial advisers, credit bureaus, entities that are part of Discovery Limited or industry regulatory bodies ("Sources"), any information in the public domain and further processing of such information to consider my dispute/complaint.

Signature of main member	<input type="text"/>	Date	<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"/>
--------------------------	----------------------	------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

 **Please only sign if the information is true, complete and correct**

Representative's name (if applicable)	<input type="text"/>
---------------------------------------	----------------------

Representative's relationship to member	<input type="text"/>
---	----------------------

Signature of representative	<input type="text"/>	Date	<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"/>
-----------------------------	----------------------	------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------