Allied Therapeutic and Psychology additional funding application form 2025

Executive, Comprehensive and Priority Plans only

Discovery Health Medical Scheme

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**, PO Box 784262, Sandton, 2146, 1 Discovery Place, Sandton, 2196**.**

Purpose of the form

This application form is for members on the Executive, Comprehensive and Priority Plans to apply for additional cover for allied, therapeutic and psychology healthcare services. This application process is for cover above the annual benefit limit for conditions that do not form part of the Allied, Therapeutic and Psychology Extender Benefit. Make reference to the footnote that indicates the expiry date of the form. Download the latest version of all forms from **www.discovery.co.za** under Medical Aid > Find documents and certificates.

What you must do

- All relevant sections must be signed by the patient. The patient must complete section 1 and section 2 and must sign section 1 of the application form.
- Fill in the form in black ink and print clearly or complete the form digitally. You can access a list of the approved digital signature providers on **www.discovery.co.za**, under Medical Aid > Find documents and certificates > Application forms.
- Read “Important information” section on page 2.
- Take this application form to your healthcare professional to complete the relevant sections.
- Email the completed form to **ATmotivations@discovery.co.za**
- Refer to relevant benefit guide for complete information. Up-to-date forms are available on **www.discovery.co.za** under Medical Aid > Find documents and certificates.

1. Patient information (to be completed by the patient)

Title | Initials

First name(s)

Surname

ID or passport number | Membership number

Telephone (H) | Telephone (W)

Cellphone

Email

(If the patient is a minor, main member or guardian to sign)

Signature of patient | Date D D M M Y Y Y Y

⚠ **I acknowledge that I have read and understood the conditions for additional benefits under ''Important information'' (Section 3), on page 2.**

2. Healthcare professional's details (to be completed by relevant healthcare professionals)

2.1. List all healthcare professionals not included in this application form (for example: GPs, specialists, other allied, therapeutic and psychology professionals)

Name	Discipline

2.2. Primary and secondary diagnosis details

2.3. Current medicine the patient is on, relevant to the primary diagnosis

3. Important information for the patient

I give permission for my healthcare professional to provide Discovery Health Medical Scheme and Discovery Health (Pty) Ltd (as administrator) with my diagnosis and other relevant clinical information required to review my application for additional allied, therapeutic and psychology benefits.

I understand that:

3.1. Funding for additional allied, therapeutic and psychology services is subject to meeting benefit entry requirements as determined by Discovery Health Medical Scheme.

3.2. Funding for additional allied, therapeutic and psychology services will only be effective once I have reached the annual Allied and Therapeutic Benefit limit applicable on my plan type.

3.3. The outcome of the decision will be sent via email to the patient's email address as stated under patient details.

3.4. Only services from biokineticists, chiropractors, occupational therapists, physiotherapists, psychologists, social workers (in mental health) and speech and hearing therapists (speech-language therapists and audiologists) will be considered for funding.

3.5. Discovery Health Medical Scheme will pay the claims for the approved additional allied, therapeutic and psychology services from the available funds in my Medical Savings Account according to the payment option I selected. Once I reach the Above Threshold Benefit, all of the approved allied, therapeutic and psychology claims will pay at 100% of the Discovery Health Rate.

3.6. For Comprehensive and Priority Plans, these claims will be subject to the Above Threshold Benefit limit.

3.7. Members on the Classic Smart Comprehensive plan, need to reach the Annual Threshold to have cover for day-to-day medical expenses.

3.8. Funding for additional healthcare services is effective from the date Discovery Health Medical Scheme receives a completed, signed form.

3.9. The approved additional allied, therapeutic and psychology benefits only applies for the dependant whose date of birth is on the application form.

3.10. I may need to send an updated or new application form, if required by Discovery Health Medical Scheme or its advisory panels (representatives from the relevant professional body).

3.11. Consent for processing my personal information, as per privacy Statement:

3.11.1. I give the Scheme and the administrator consent to have access to and process all information (including general, personal, medical or clinical information) that is relevant to this application.

3.11.2. I understand that this information will be used for the purposes of applying for and assessing my funding request for additional allied, therapeutic and psychology services.

3.11.3. I give permission to the Scheme and the administrator to share my medical and clinical information with the external advisory panel, should they need it.

3.11.4. I consent to the Scheme and the administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical information) to my healthcare provider, to administer the additional allied, therapeutic and psychology benefits.

4. Notes to healthcare professional

4.1. The healthcare professional's fee for completion of this form will be reimbursed as per their relevant report writing billing code and/or billing guidelines, on submission of a separate claim. Payment of the claim is from the day-to-day benefits (if applicable to the member's plan type), subject to Discovery Health Medical Scheme rules and availability of funds and where the member is a valid and active member at the service date of the claim.

4.2. In line with legislative requirements, please ensure that when using your report writing billing code, you submit the ICD-10 diagnosis code(s). As per industry standards, the appropriate ICD-10 code(s) to use for this purpose would be those reflective of the actual condition(s) for which the form was completed. If funding for multiple conditions is applied for, then it would be appropriate to list all the relevant ICD-10 codes.

4.3. I understand that panel members from the relevant advisory panel (representatives from the relevant professional body) will review the information I provide by completing this form as well as the motivation I attach. This information will form part of the final recommendation and funding decision as communicated to the patient on the completion of this application process.

4.4. We will not consider cover for both a chiropractor and physiotherapist for the same condition.

4.5. We will not consider cover for both a psychologist and a social worker for the same condition.

4.6. As a healthcare funder, Discovery Health Medical Scheme funds treatments related to medical or clinical needs. When a medical scheme member applies for funding for additional allied, therapeutic and psychology benefits after they reached their annual family limit for the year, it is important to note that the additional benefit does not include therapies related to disorders of a scholastic nature (educational), including but not limited to school readiness testing. The additional benefit for allied, therapeutic and psychology services is not designed to fund any conditions of a non-clinical or non-medical nature. If the therapy is clinically indicated, we will require supporting information for current or retrospective review.

4.7. Certain assessments are not considered for funding through this application process, they are funded from day-to-day benefits subject to the annual family Allied, Therapeutic and Psychology Benefit limit.

4.8. Funding for additional healthcare services will only commence from the date Discovery Health Medical Scheme receives a completed, signed form. Failure to complete all relevant information under each section of this form can result in the application being sent back for further information, in order to ensure that the review process can take place.

5. Biokineticist section

Please note: This section is only to be completed by the treating healthcare professional. If not, the form won't be accepted.

Membership number | Patient age (N N) | Patient date of birth (D D M M Y Y Y Y)

Healthcare professional first name(s)

Healthcare professional surname

BHF practice number

Special interest

Telephone (W)

Email

I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.

Signature of healthcare professional | Date (D D M M Y Y Y Y)

5.1. Information about the patient's past conditions

5.1.1. Diagnosis details of current diagnosis

Please specify detailed ICD code(s)	Description	Date and nature of incident / onset	Duration	
			< 12 weeks	> 12 weeks

5.1.2. If your patient has a spine-related condition, please complete and attach the relevant biokinetic spinal evaluation form which can be found on the Healthcare Professional Zone at **www.discovery.co.za**

Condition	
Cervical spine	Yes ☐ No ☐
Lumbar spine	Yes ☐ No ☐

5.2. Information about the present treatment required referring to the above ICD-10 code

Consultation or procedure code(s)	**Length of sessions (minutes)**	**Number of treatments required per week or month**	**Number of total sessions required for the remainder of the current benefit year to complete current diagnosis treatment**

Attach description to show what phase the member is currently in.

5.2.1. Motivation for treatment for above mentioned ICD-10 code (include impact of treatment to date on functionality)

5.2.2. Goals for further treatment sessions

5.2.3. Number of sessions used

Year	**Total sessions current year**	**Applied for any additional benefit**	**Number of sessions required**	**Number of sessions approved**	**Number of sessions used**
2019		Yes ☐ No ☐			
2020		Yes ☐ No ☐			
2021		Yes ☐ No ☐			
2022		Yes ☐ No ☐			
2023		Yes ☐ No ☐			
2024		Yes ☐ No ☐			

Original start of therapy D D M M Y Y Y Y

Start date of therapy in current year D D M M Y Y Y Y

Last date of therapy in current year D D M M Y Y Y Y

Total number of sessions and frequency in current year:

5.2.4. Description of past treatment sessions to date, of above mentioned ICD-10 code (please also indicate the procedure codes used)

5.2.5. Relevant patient history (include previous diagnoses, occupational and social functioning, previous treatment, hospitalisation, history of primary diagnosis, include any supporting documents such as scan reports, etc.)

6. Chiropractor section

Please note: This section is only to be completed by the treating healthcare professional. If not, the form won't be accepted.

Membership number | Patient age N N | Patient date of birth D D M M Y Y Y Y

Healthcare professional first name(s)

Healthcare professional surname

BHF practice number

Special interest

Telephone (W)

Email

I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.

Signature of healthcare professional | Date D D M M Y Y Y Y

6.1. Information about the patient's condition

6.1.1. Diagnosis details

Please specify detailed ICD-10 code(s)	Description	Date and nature of incident / onset	Duration	
			< 12 weeks	> 12 weeks

6.2. Information about the present treatment required

Consultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year to complete current diagnosis

Attach description to show what phase the member is currently in.

6.2.1. Motivation for treatment of treatment (include impact of treatment to date on functionality)

6.2.2. Number of sessions used

Year	Total sessions current year	Applied for any additional benefit	Number of sessions required	Number of sessions approved	Number of sessions used
2019		Yes ☐ No ☐			
2020		Yes ☐ No ☐			
2021		Yes ☐ No ☐			
2022		Yes ☐ No ☐			
2023		Yes ☐ No ☐			
2024		Yes ☐ No ☐			

Original start date of therapy D D M M Y Y Y Y

Start date of therapy in current year D D M M Y Y Y Y

Last date of therapy in current year D D M M Y Y Y Y

Total number of sessions and frequency in current year:

6.2.4. Description of past treatment sessions to date (please also indicate the procedure codes used)

6.2.5. Relevant patient history (include previous diagnoses, occupational and social functioning, previous treatment, hospitalisation, history of primary diagnosis, include any supporting documents such as scan reports, etc.)

7. Occupational therapist section

Please note: This section is only to be completed by the treating healthcare professional. If not, the form won't be accepted.

Membership number Patient age N N Patient date of birth D D M M Y Y Y Y

Healthcare professional first name(s)

Health care professional surname

BHF practice number

Special interest

Telephone (W)

Email

I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.

Signature of healthcare professional

Date

7.1. Information about the patient's condition

7.1.1. Diagnosis details

Please specify detailed ICD-10 code(s)	Description	Date and nature of incident / onset	Duration	
			< 12 weeks	> 12 weeks

7.2. Information about the treatment required

Consultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year to complete current treatment

7.2.1. Motivation for treatment (include impact of treatment to date on functionality)

7.2.2. Detailed goals for further therapy

7.2.3. Number of sessions used

Year	Total sessions current year	Applied for any additional benefit	Number of sessions required	Number of sessions approved	Number of sessions used
2019		Yes ☐ No ☐			
2020		Yes ☐ No ☐			
2021		Yes ☐ No ☐			
2022		Yes ☐ No ☐			
2023		Yes ☐ No ☐			
2024		Yes ☐ No ☐			

Original start date of therapy D D M M Y Y Y Y

Start date of therapy in current year D D M M Y Y Y Y

Last date of therapy in current year D D M M Y Y Y Y

Total number of sessions and frequency in current year:

7.2.4. Brief summary of occupational therapy to date (please also indicate the procedure codes used)

7.2.5. Brief history of patient's pre-morbid functioning and relevant patient history (include any supporting documents such as scan reports, etc.)

Motivation for treatment of adults – please include additional motivation with this application including:

Information about assistance required for participation in activities of daily living, functional transfers and upper limb function, cognitive and/or perceptual function, and pre-morbid work/school/university history. Please note: Standardised tests and scores should be indicated in reports when formal testing was included in the assessment.

Motivation for treatment of children – please include additional motivation with this application including:

Information about impact on development, behaviour, school and social functioning, as well as relevant birth and background history. Please note: Standard scores should be indicated in reports when formal testing was included in the assessment. Please include additional assessment and progress reports with this application for paediatric cases.

8. Physiotherapist section

Please note: This section is only to be completed by the treating healthcare professional. If not, the form won't be accepted.

Membership number | Paitent age N N | Patient date of birth D D M M Y Y Y Y

Healthcare professional first name(s)

Healthcare professional surname

BHF practice number

Special interest

Telephone (W)

Email

I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.

Signature of healthcare professional

Date D D M M Y Y Y Y

8.1. Information about the patient's condition

8.1.1. Diagnosis details

Please specify detailed ICD-10 code(s)	Description	Date and nature of incident / onset	Duration	
			< 12 weeks	> 12 weeks

8.2. Information about the treatment required

Consultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year to complete current treatment

Attach description to show what phase the member is currently in.

8.2.1. Motivation for treatment (include outcome measures used and scores/impact of treatment to date on functionality)

8.2.2. Goals for further treatment sessions

8.2.3. Number of sessions used

Year	Total sessions current year	Applied for any additional benefit	Number of sessions required	Number of sessions approved	Number of sessions used
2019		Yes ☐ No ☐			
2020		Yes ☐ No ☐			
2021		Yes ☐ No ☐			
2022		Yes ☐ No ☐			
2023		Yes ☐ No ☐			
2024		Yes ☐ No ☐			

Original start date of therapy D D M M Y Y Y Y

Start date of therapy in current year D D M M Y Y Y Y

Last date of therapy in current year D D M M Y Y Y Y

Total number of sessions and frequency in current year:

8.2.4. Description of past treatment sessions to date (please also indicate the procedure codes used)

8.2.5. Relevant patient history (include previous diagnoses, occupational and social functioning, previous treatment, hospitalisation, birth history, milestones and history of primary diagnosis. Include any supporting documents such as scan reports, etc.)

9. Psychologist section

Please note: This section is only to be completed by the treating healthcare professional. If not, the form won't be accepted.

Membership number Patient age N N Patient date of birth D D M M Y Y Y Y

Healthcare professional first name(s)

Healthcare professional surname

Tick the relevant box:

Are you a: Clinical psychologist ☐ Counselling psychologist ☐ Educational psychologist ☐ Neuropsychologist ☐

BHF practice number

Special interest

Telephone (W) Cellphone

Email

I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2

Signature of healthcare professional

Date D D M M Y Y Y Y

9.1 Information about the patient's condition

9.1.1. Diagnosis details

Please specify detailed ICD-10 code(s)	Description	Date and nature of incident / onset	Duration	
			< 12 weeks	> 12 weeks

9.1.2. Please provide the DSM-5 diagnosis

Current GAF and/or GARF	
Pre-treatment GAF and/or GARF	
DSM-5	

Additional/supporting comments about diagnosis, including impact on social and occupational/scholastic functioning (if a paediatric assessment has been done, please include/attach report recommendations):

9.2 Information about the treatment required

Consultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year to complete current diagnosis

9.2.1. Indicate current method(s) of treatment

9.2.2. Treatment to date (indicate impact of treatment to date on social and occupational functioning. For children, include information about impact on development, behaviour, school and social functioning.)

9.2.3. Motivation for additional treatment

9.2.4. If you are treating multiple members of the same family, please motivate and give clear reasons for this

9.2.5 Relevant patient history (include previous diagnoses, occupational and social functioning, previous treatment, hospitalisation, history of primary diagnosis.) Please also indicate the procedure codes used.

9.2.5.1. Previous diagnosis

9.2.5.2. Previous symptom presentations

9.2.5.3. Previous occupational and social functioning

9.2.5.4. Previous treatment

9.2.5.5. Previous hospitalisation

9.2.5.6. History of primary diagnosis (including a description of stress or for trauma and stress or-related disorders)

9.2.6. Number of sessions used

Year	Total sessions current year	Applied for any additional benefit	Number of sessions required	Number of sessions approved	Number of sessions used
2019		Yes ☐ No ☐			
2020		Yes ☐ No ☐			
2021		Yes ☐ No ☐			
2022		Yes ☐ No ☐			
2023		Yes ☐ No ☐			
2024		Yes ☐ No ☐			

Original start date of therapy D D M M Y Y Y Y

Start date of therapy in current year D D M M Y Y Y Y

Last date of therapy in current year D D M M Y Y Y Y

Total number of sessions and frequency in current year:

10. Social Worker (additional mental healthcare benefits)

Confirm that you are a member of the Discovery Health Social Worker in the Mental Health Network, before completing the below section.

Membership number Patient age N N Patient date of birth D D M M Y Y Y Y

Healthcare professional first name(s)

Healthcare professional surname

BHF practice number

Special interest

Telephone (W)

Email

I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.

Signature of healthcare professional

Date D D M M Y Y Y Y

10.1. Information about the patient's condition

10.1.1. Diagnosis details

Please specify detailed ICD-10 code(s)	Description	Date and nature of incident / onset	Duration	
			< 12 weeks	> 12 weeks

10.1.2. Please provide the DSM-V diagnosis

DSM-V	

If the application is for psychotherapy treatment for members younger than 13 years of age, the Scheme will require the latest Diagnostic and Statistical Manual of Mental Disorders (DSM-V) form including the **World Health Organisation Disability Assessment Schedule - Children and Youth version (WHODAS-Child) form**.

Additional/supporting comments about diagnosis, including impact on social and occupational/scholastic functioning (if a paediatric assessment has been done, please include/attach report recommendations):

10.2. Information about the treatment required

Consultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year to complete current diagnosis

Attach description to show what phase the member is currently in.

10.2.1. Indicate method(s) of treatment and treatment to date

10.2.2. Relevant patient history

(include previous diagnoses, occupational and social functioning, previous treatment, hospitalisation, history of primary diagnosis)
Please also indicate the procedure codes used.

10.2.3. Number of sessions used

Year	Total sessions current year	Applied for any additional benefit	Number of sessions required	Number of sessions approved	Number of sessions used
2019		Yes ☐ No ☐			
2020		Yes ☐ No ☐			
2021		Yes ☐ No ☐			
2022		Yes ☐ No ☐			
2023		Yes ☐ No ☐			
2024		Yes ☐ No ☐			

Original start date of therapy D D M M Y Y Y Y

Start date of therapy in current year D D M M Y Y Y Y

Last date of therapy in current year D D M M Y Y Y Y

Total number of sessions and frequency in current year:

10.3. Information about the treatment required

Consultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year to complete current diagnosis

10.3.1. Indicate method(s) of treatment and treatment to date

10.3.2. Motivation for additional treatment

10.3.3. Treatment to date including additional sessions in the past three years (indicate impact of treatment to date on social and occupational functioning. For children, include information about impact on development, behaviour, school and social functioning.)

11. Speech-language therapist and audiologist section

Please note: This section is only to be completed by the treating healthcare provider. If not, the form won't be accepted.

Membership number | Patient age N N | Patient date of birth D D M M Y Y Y Y

Healthcare professional first name(s)

Healthcare professional surname

BHF practice number

Special interest

Telephone (W) | Email

I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.

Signature of healthcare professional | Date D D M M Y Y Y Y

This application should be supported by a comprehensive report.

11.1. Information about the patient's condition

11.1.1. Diagnosis details

Please specify detailed ICD-10 code(s)	Description	Date and nature of incident / onset	Duration	
			< 12 weeks	> 12 weeks

11.2. Information about the treatment required

Consultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year to complete current diagnosis

Attach description to show what phase the member is currently in.

11.2.1 Motivation for treatment (indicate impact of treatment to date on functionality)

11.2.2. Goals of further treatment sessions

11.2.3. Number of sessions used

Year	Total sessions current year	Applied for any additional benefit	Number of sessions required	Number of sessions approved	Number of sessions used
2019		Yes ☐ No ☐			
2020		Yes ☐ No ☐			
2021		Yes ☐ No ☐			
2022		Yes ☐ No ☐			
2023		Yes ☐ No ☐			
2024		Yes ☐ No ☐			

Original start date of therapy D D M M Y Y Y Y

Start date of therapy in current year D D M M Y Y Y Y

Last date of therapy in current year D D M M Y Y Y Y

Total number of sessions and frequency in current year:

11.2.4. Description of past treatment sessions to date (please also indicate the procedure codes used)

11.2.5. Relevant patient history (include previous diagnoses, occupational and social functioning, previous treatment, hospitalisation etc. For children please include the child’s birth history, milestones and history of primary diagnosis). Please include additional assessment and progress reports to this application for paediatric cases.