REGULAR FORCE
MEDICAL CONTINUATION FUND

PPS Centurion Square
Cnr Heuwel Avenue and Gordon Hood Road
Centurion
PO Box 3799, Pretoria, 001

Exception Management Application Form

Purpose:

The purpose of this application form is to apply for additional benefits for clinically appropriate healthcare needs once standard allocated benefits have been depleted.

Please note:

1. The completed form must be sent, with a letter of motivation, to the Regular Force Medical Continuation Fund for referral to the Clinical Committee for review.
2. Exception Management payments will only be made by the committee in its absolute discretion provided it is satisfied that extreme healthcare needs that is in line with clinical protocols and healthcare appropriateness.
3. Exception Management payments will not be considered in advance of any anticipated expense.
4. If services being applied for is available within the SAMHS, the request will not be considered.
5. All claims requiring additional benefit payments must be submitted with this application.
6. The application will not be submitted to the committee should any section of this form be incomplete.
7. Email the form along with supporting documentation to preauth@rfmcf.co.za for review.
8. Feedback will be provided to the Principal Member per email once a decision has been made.

Membership details:

Member Name: _____

Membership number: _____

Email Address: _____

Cell Phone Number: _____

Physical Address: _____

_____

_____

Patient Details

Name & Surname	
Beneficiary/Dependant Code	
Date of Birth	

Who referred the patient for specified treatment (mark with X):

	SAMHS		Private Healthcare Provider		Other
Name of the referring provider:					

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Details of Additional Benefits being applied for

Doctor Name and Surname	
Doctor Practice Number	
Contact Number of Treating Doctor	
Treatment (Service) Date	
Diagnosis	
Treatment/Healthcare Services Required	
Expected cost of treatment required	
Is future healthcare treatment expected? If Yes, elaborate on expected future treatment.	

Brief motivation for application:

_____
_____
_____
_____
_____
_____
_____
_____

I _____ the undersigned, hereby certify that the information stated in this document is true and correct.

Principal Member Signature: _____

Date: _____

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RFMCF specific membership benefit allocation (For office use only)

Type of Benefit	Limits applicable	Current year claims experience
Hospitalisation		
Major Medical Services		
Day-to-Day Healthcare Services		
Medication		
Optical Services		
Oral Health Services		
Preventative Services		
Ambulance Services		
Medical Appliances, Supplementary and Auxiliary Services		
Other		

Checklist (For office use only):

Was a network provider in the patient's km radius?	Yes/No
If no, could the member have seen a network provider in a 50km radius?	Yes/No
If the doctor is not on the network, and future treatment is expected, did you send the provider information to the Provider Relations Department?	Yes/No

Approved/Declined: _____

Name and Surname of Decision Maker: _____

Signature of Decision Maker: _____

Date: _____