



**IMPORTANT:**

- 1. It is compulsory to complete all sections of this form to prevent delays in processing your application.
- 2. Please keep copies of all documentation.
- 3. Attach supporting documentation e.g. account of service provider, receipt if account is paid by member.

**DISCLAIMER:** Ex Gratia approval is not guaranteed, but subject to assessment based on clinical protocols. The rate of reimbursement will be between 80% and 100% of the POLMED rate. Completion of the form by the doctor will be reimbursed at 80% of POLMED rates if no benefits are left.

## Member Details

Membership Number

Surname

First Name (in full)

Title/Rank       Initials       Number of Dependants

Identity Number       Date of Birth

Occupation

## Contact Details

Address

Code

Telephone (Home)       Telephone (Work)

Cellphone       Fax

Email

## Motivation by Medical Practitioner relating to Ex Gratia request

**Diagnosis** (or attach doctor's detailed letter of motivation and photograph)

Medical History \_\_\_\_\_

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Continued



## Motivation by Medical Practitioner relating to Ex Gratia request - Continued

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Doctor's Signature \_\_\_\_\_

## Details of Ex Gratia Assistance

Please state the details of your medical claims.

Type of illness      Dependant  \_\_\_\_\_  
    Dependant  \_\_\_\_\_  
    Dependant  \_\_\_\_\_

### Suppliers of medical services relating to ex Gratia

|                    |                      |                      |                              |                        |                      |
|--------------------|----------------------|----------------------|------------------------------|------------------------|----------------------|
| 1. Provider's Name | <input type="text"/> | <input type="text"/> | Ex Gratia application amount | R <input type="text"/> | <input type="text"/> |
| Practice Number    | <input type="text"/> |                      |                              |                        |                      |
| 2. Provider's Name | <input type="text"/> | <input type="text"/> | Ex Gratia application amount | R <input type="text"/> | <input type="text"/> |
| Practice Number    | <input type="text"/> |                      |                              |                        |                      |
| 3. Provider's Name | <input type="text"/> | <input type="text"/> | Ex Gratia application amount | R <input type="text"/> | <input type="text"/> |
| Practice Number    | <input type="text"/> |                      |                              |                        |                      |
| 4. Provider's Name | <input type="text"/> | <input type="text"/> | Ex Gratia application amount | R <input type="text"/> | <input type="text"/> |
| Practice Number    | <input type="text"/> |                      |                              |                        |                      |
| 5. Provider's Name | <input type="text"/> | <input type="text"/> | Ex Gratia application amount | R <input type="text"/> | <input type="text"/> |
| Practice Number    | <input type="text"/> |                      |                              |                        |                      |

Signature of Member \_\_\_\_\_

Date

**RETURN ADDRESS:** Hand it in at any one of the Medscheme walk-in branches  
 Fax: 0860 104 114 Email: polmedspecialcases@medscheme.co.za  
 Private Bag X16, Arcadia, 0007