POLMED
OUR INVESTMENT OUR HEALTH OUR FUTURE

Clinical Dispute Resolution Form

Membership Number ☐☐☐☐☐☐☐☐☐☐☐☐☐ Dependant Code ☐☐☐

Appellant's Name _____

RSA ID Number ☐☐☐☐☐☐☐☐☐☐☐☐☐

Aquarium ☐ Marine ☐

Contact number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Email Address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

This form must be completed if a member is not satisfied with the outcome of an application and wishes to formally dispute the decision. Please email the completed form along with all supporting documents to polmedappeals@medscheme.co.za.

TREATING PROVIDER INFORMATION

Provider Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Practice Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Provider Contact Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

CLINICAL INFORMATION

Diagnosis ICD-10 Code ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Treatment Date D D M M Y Y Y Y

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DISPUTE INFORMATION

Reason for Dispute

SUPPORTING DOCUMENTS

1.
2.
3.

Signature of Member

Date D D M M Y Y Y Y

Referred to Clinical Committee ☐ Yes ☐ No

Date Referred D D M M Y Y Y Y

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CLINICAL COMMITTEES RULING

CLINICAL FEEDBACK

1. Approved	☐	3. Declined	☐
2. Request Additional Information	☐	4. Date Finalised	D D M M Y Y Y Y