

## BANKMED GUIDELINES ON THE APPROVAL OF THE EXTENSION OF BENEFIT FOR PHYSIOTHERAPY

### GENERAL GUIDELINES:

The following guidelines will be used on the approval of extension of benefit for Physiotherapy:

1. Extension of benefit will only be considered if the relevant information and documentation required as indicated on the **Pre-authorisation Form for Extension of Benefit** are supplied;
2. The pre-authorisation form must be filled in by the service provider and contain the following important information:
  - a) an agreed upon rehabilitation period (Start Date and Completion Date);
  - b) Total cost of treatment/session;
  - c) Cost payable by the fund;
  - d) Cost payable by the member;
  - e) Risk/Diagnosis Classification Code (please see list below);
  - f) Signature of the physiotherapist, member and the fund representative as proof of agreement of such extension of benefit.
3. All request for extension of benefit will be referred to the Ex Gratia Committee;
4. Condition/diagnosis that is related to fund exclusion will not be considered. For example: attempted suicide;
5. No extension of benefit will be considered for condition/diagnosis that can be claimed from the third party. For example: MVA , Injury on Duty;
6. No extension of benefit will be considered for Bankmed Care option;
7. Members/dependants who have utilized their overall Auxiliary benefit limit per family will not be considered for extension of benefit;
8. Ex Gratia will not be considered for member portion e.g. member portion of the benefit booster and member portion of the approved extended benefit.

### **REQUIREMENTS FOR CLAIMS SUBMISSION:**

1. All claims submitted must indicate the name of the physiotherapist attending to the patient at the time of service;
2. All claims submitted must reflect the Risk/Diagnosis Classification Code as per Risk/Diagnosis Classification Code and Description indicated below:

Risk/Diagnosis Classification Code	Description
C1	Postural Syndromes
C2	Sport related injuries
C3	Degenerative conditions
C4	Spinal injuries or conditions
C5	Neurological conditions
C6	Peripheral injuries or conditions
C7	In hospital procedures
C8	Chest and airway related conditions
C9	Wound and related conditions
C10	Pre- and Post natal conditions
C11	Pre- and Post Surgery
C12	Rehabilitation
C13	Trauma

**PRE-AUTHORISATION FORM FOR EXTENSION OF BENEFIT  
(PHYSIOTHERAPY)**

**1. MEMBERSHIP DETAILS:**

MEMBERSHIP NUMBER: \_\_\_\_\_

MAIN MEMBER NAME &amp; SURNAME: \_\_\_\_\_

MAIN MEMBER DOB: \_\_\_\_\_

PATIENT NAME &amp; SURNAME: \_\_\_\_\_

PATIENT DOB: \_\_\_\_\_

**2. SERVICE PROVIDER DETAILS:**

PRACTICE NAME: \_\_\_\_\_

PRACTICE NUMBER: \_\_\_\_\_

**3. PATIENT TREATMENT DETAILS:**

DIAGNOSIS: \_\_\_\_\_

\_\_\_\_\_

REFERRED BY MEDICAL PRACTITIONER?

 Yes

 No

(If referred, please attach referral letter)

PROGRESS REPORT &amp; MOTIVATION:

(Please attach progress report &amp; motivation)

TREATMENT PLAN:

 Ongoing Case 

 New Case: 

RISK/DIAGNOSIS CLASSIFICATION CODE: \_\_\_\_\_

Tariff Code	No. of Sessions/Treatment	Cost per Session/treatment (NAMAF Tariff)	Total Cost (NAMAF Tariff)	Sessions/Treatment Completion Date
<b>TOTAL COST OF TREATMENT</b> (From the 1 <sup>st</sup> session to the last session)				

 \_\_\_\_\_  
 SERVICE PROVIDER NAME & SIGNATURE

 \_\_\_\_\_  
 DATE

**FOR OFFICIAL USE ONLY:**

**1. TOTAL STANDARD BENEFIT:**

STANDARD BENEFIT: N\$ \_\_\_\_\_

BENEFIT BOOSTER: N\$ \_\_\_\_\_

(Only 70% of the NAMAf tariff is paid, 30% payable by the member)

**TOTAL BENEFIT (STANDARD BENEFIT + BENEFIT BOOSTER):**N\$ \_\_\_\_\_

**2. TOTAL ADDITIONAL BENEFIT:**

TOTAL COST OF TREATMENT (NAMAf TARIFF): N\$ \_\_\_\_\_

LESS

TOTAL BENEFIT (STANDARD BENEFIT + BENEFIT BOOSTER): N\$ \_\_\_\_\_

ADDITIONAL BENEFIT APPLIED: N\$ \_\_\_\_\_

**ADDITIONAL BENEFIT APPROVED:** N\$ \_\_\_\_\_

MEMBER'S PORTION (Approximate Only): N\$ \_\_\_\_\_  
(Including 30% member portion of the Benefit Booster)

COMMENT:

\_\_\_\_\_

\_\_\_\_\_

**APPROVED BY:**

\_\_\_\_\_  
NAME & SIGNATURE

\_\_\_\_\_  
DATE

Please fax or e-mail form and relevant documentation to:

Fax No. (061) 287 6176

E-mail: [mhc@methealth.com.na](mailto:mhc@methealth.com.na)

**Important:**  
*The extended benefit will be paid from the member's Auxiliary benefit limit while the benefit is available. If the member used up the Auxiliary benefit for other services, the approved extended benefit will no longer be valid and the claim must be paid by the member. Please inform member accordingly.*