momentum health

PSYCHIATRIC APPLICATION FORM
OUTPATIENT MENTAL HEALTH BENEFITS

For out-of-hospital psychotherapy sessions in lieu of hospitalisation, we require the treating physician to kindly complete this form and return it to the details provided on page 3 of this form.

PLEASE USE BLOCK LETTERS FOR ALL SECTIONS
***Compulsory fields**

1. MEMBER AND PATIENT INFORMATION

MAIN MEMBER DETAILS

Membership number

Medical scheme name | Benefit option

Title | Initials | ID number*

Full name and surname

Email address

PATIENT DETAILS

Dependant code

Title | Initials | ID number*

Full name and surname

Contact numbers | Home | Work

Cell phone

Postal address

Postal code

Email address

2. MEDICAL PRACTITIONER'S INFORMATION

DOCTOR DETAILS

Practice number

Initials | Speciality

Surname

Contact numbers | Work | Fax number

Cell phone

Postal address

Postal code

Email address

Membership number | **Doctor's practice number**

3. CLINICAL EXAMINATION

Date of diagnosis | D | D | M | M | Y | Y | Y | Y |

ICD-10 code(s)

Consultation/procedure code(s)	Quantity requested

CURRENT MEDICATION

CLINICAL INDICATION/MOTIVATION

Referring doctor's signature

Date D D M M Y Y Y Y

Membership number

Doctor's practice number