AECI®
MEDICAL AID SOCIETY

REQUEST FOR APPEAL OF A SCHEME BENEFIT EXCLUSION

This form can be used to request funding for medical treatment that is an exclusion in accordance with the Scheme Rules, but that is judged by a healthcare provider to be clinically appropriate and necessary.

Important

- The case will not be submitted to the Scheme should any section of this form be incomplete.
- This request must be accompanied by a complete medical/clinical motivation and report, supplied by the treating doctor (short notes and prescriptions will not be considered on their own). All costs for the abovementioned motivations and/or reports will be for the member's own account and will not be settled by AECI Medical Aid Society.
- The appeal will be sent to a contracted Medical Advisor, who will then send the Scheme a recommendation.
- Requests for an appeal will only be considered by the Scheme if it is satisfied that the excluded benefit would be clinically appropriate for the beneficiary or that there are no other treatment options available.
- The completion of this request form in no way implies that the appeal will be successful and that the treatment will be paid, as each case is considered according to its own merits.

Please give details of the benefit exceeded, and to whom payment must be made should the application be successful:

Benefits exceeded	
Payee	
Name of Member	
Postal Address	
Age	
Membership Number	

TO BE COMPLETED BY THE MEMBER

Net Income	**R**
Expenditure	**R**
Net Cash Surplus/Deficit	**R**

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

Signature		Date	

MEDICAL CERTIFICATE TO BE COMPLETED BY HEALTHCARE PROFESSIONAL

Diagnosis
Medical History
Treatment & Medication Required

Doctor's Name		Practice Number	
Signature		Date	