

Applying for cover for Lymphoedema 2026



Contact details
Tel: 0860 002 133 • www.sabmas.co.za

Who we are

SAB Medical Aid (referred to as 'the Scheme'), registration number 1209, is a not-for-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the Administrator') is a separate company and an authorised financial services provider and is responsible for the administration of your membership on behalf of the Scheme.

What you must do

- Fill in the form in black ink and print clearly. Alternatively, complete it electronically by typing in the fields below.
- Ensure the form and photographs are sent to us by email at oncology@sabmas.co.za.
- Only applications received from healthcare professionals will be accepted.
- You will receive a letter informing you of our decision and what to do next for approved requests. If you have any questions, you can contact us on **0860 002 133**.

1. Patient's details

Title		Initials	
Surname			
First name(s) (as per identity document)			
ID or passport number		Membership number	
Telephone (H)		Telephone (W)	
Cellphone			
Email			
Relationship to main member			

2. Lymph node status

Regional node dissection	☐ Yes	☐ No	If yes, state region:	
Sentinel lymph node biopsy	☐ Yes	☐ No		
Chemotherapy	☐ Yes	☐ No	☐ Still to be decided	
If yes	☐ Adjuvant	☐ Neoadjuvant	☐ Oral	
Radiation therapy	☐ Yes	☐ No	☐ Still to be decided	☐ Still due for radiology
If yes, state area				

3. Existing medical conditions and co-morbidities

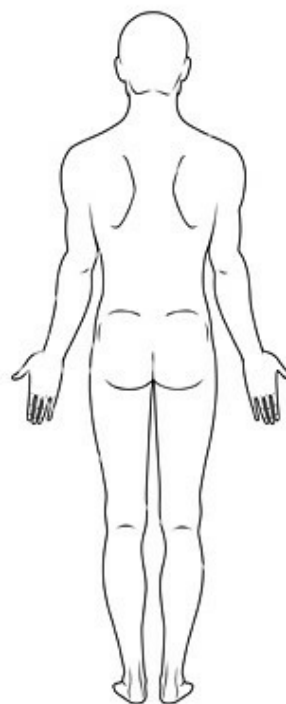
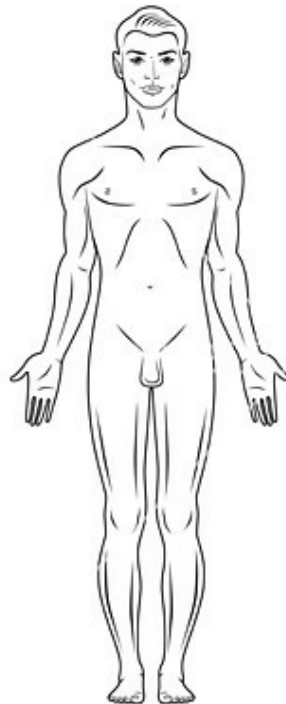
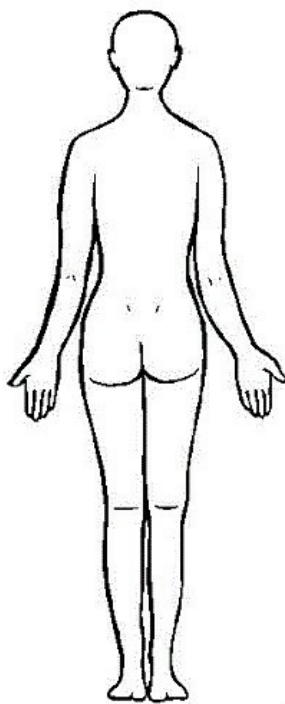
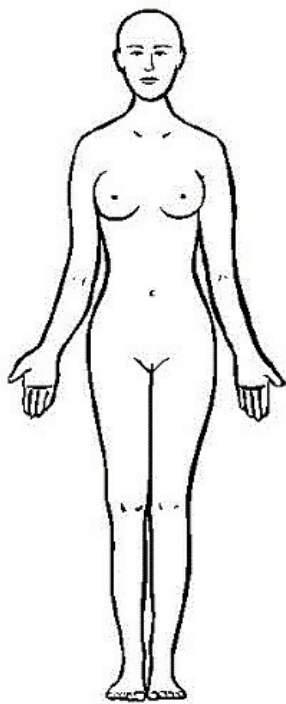
4. Any factors that may complicate, influence or affect prognosis for lymphoedema treatment

(If more space is required, please provide on a separate letter attached to this motivation)

5. Previous lymphoedema treatment (include nature of treatment and duration)

6. Limb circumference measurements (in cm)

Upper limb:	Right	Left	Lower limb:	Right	Left
Index finger			Big toe		
Thumb			Metatarsophalangeal		
Metacarpophalangeal			Mid-foot		
Distal wrist crease			Ankle		
cm			cm		
cm			cm		
cm			cm		
cm			cm		
cm			cm		
Elbow			Knee		
cm			cm		
cm			cm		
cm			cm		
cm			cm		
cm			cm		
Total limb vol:			Total limb vol:		
Excess total limb vol (%):			Excess total limb vol (%):		



7. Proposed treatment

Lymphoedema therapist

BHF practice number

Date of staging

Staging

Treatment start date

Initial consultation

Requested code

Cost

R

R

R

Total cost

R

Treatment

Requested code	Cost	Frequency	Motivation
	R		
	R		
	R		
Total cost	R		

Garments and bandages

NAPPI code	Cost	Quantity	Description
	R		
	R		
	R		
Total cost	R		

Total cost of proposed treatment

R

Healthcare professional signature

Date