CHRONIC MEDICATION BENEFIT RENEWAL FORM

A. IMPORTANT INFORMATION

1. One application must be completed per beneficiary applying for chronic medication.
2. Allow **1 working** day for the processing of your application.
3. The original prescription must be given to the provider who dispenses your medication.
4. It is essential that you submit all required information correctly and timeously as incomplete forms will not be processed.
5. Approval of chronic medication is subject to the rules and chronic protocols of the Scheme.
6. You may contact the Pharmacy Benefit Management (PBM) Team at (**041) 395 4482** or email **pbm@providence.co.za**
7. Send completed forms via fax **086 680 8855**, mail **PO Box 1672, Port Elizabeth, 6000** or e-mail **pbm@providence.co.za**

B. MEMBER DETAILS

Scheme | Option

Membership Number

Surname | First Names

Title | Date of Birth (Y Y Y Y M M D D) | ID Number

Telephone number (Home) | (Work)

Fax number (Confidential) | Cellular

Email address (Confidential)

Postal Address

Code

C. PATIENT DETAILS (Beneficiary who requires Chronic Medication)

Surname | First Names

Title | Date of Birth (Y Y Y Y M M D D) | ID Number

Telephone number (Home) | (Work)

Fax number (Confidential) | Cellular

Email address (Confidential)

The outcome of this application must be communicated to me via my email address: Yes ☐ No ☐

D. PATIENT DECLARATION

By signing below, I hereby give permission for, acknowledge and/or agree to the following:

- My (or my minor dependant's) doctor may provide clinical information regarding my (or my minor dependant's) condition to the PBM Team.
- Any information concerning this application will remain confidential at all times.
- It may be a pre-condition to the approval of the Chronic Medication Benefit that I (or my minor dependent) register and comply with the requirements of a Disease Management Programme.
- My (or my minor dependant's) doctor retains the responsibility for my (or my minor dependant's) condition, based on the understanding that I (or my dependant) also has a responsibility towards my (or my minor dependant's) own health concerns , irrespective of the outcome of this application.
- This funding authorisation is at all times subject to the Scheme rules even if a member's circumstances change after the authorisation is provided. This authorisation is not a guarantee of payment.
- This funding authorisation is based on the most appropriate clinical criteria in terms of the Scheme rules and protocols. All treatment decisions remain the responsibility of the beneficiary's health care provider irrespective of the funding decision made in terms of the Scheme rules, clinical criteria and protocols.
- PROVIDENCE shall not accept responsibility for any act, errors or omissions, loss, damage or consequences of individual responses to the treatment authorised or not authorised for funding by the Scheme.

Patient Signature (or member if patient is a minor) _____ Date (Y Y Y Y M M D D)

E. PATIENT HEALTH INFORMATION (to be completed by doctor)

Weight kg | Height m | Hip/Waist ratio | Smoker? Y N | Ave per day

Exercise: Frequency X per week | Intensity (Please tick) Low ☐ Medium ☐ High ☐

Current blood pressure mmHg | Available Blood Glucose result mmol/L | Fasting ☐ Random ☐

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PO Box 1672, Port Elizabeth, 6000 Tel: +27 41 395 4400 Fax: +27 41 395 4597
www.providence.co.za

Patient name

Membership number

F. MEDICAL PRACTITIONER DETAILS

Surname | Initials

Practice number | Speciality

Telephone number | Cellular

Fax number (Confidential)

Email address (Confidential)

The outcome of this application must be communicated to me via my email address: Yes ☐ No ☐ **OR** fax number Yes ☐ No ☐

G. CONDITION AND MEDICATION DETAILS (to be completed by doctor)

ICD-10 Code	Medication prescribed (Name, strength & dosage)	Date Medication initiated & prescriber details	Repeats

Signature of Medical Practitioner _____ Date Y Y Y Y M M D D

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