suremed health

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CHRONIC MEDICATION BENEFIT APPLICATION FORM

A. IMPORTANT INFORMATION

1. One application must be completed per beneficiary applying for chronic medication. To download an additional application form visit: www.suremedhealth.co.za
2. Allow one 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 e-mail: chronic@suremedhealth.co.za
7. Send completed form/s via e-mail: chronic@suremedhealth.co.za

B. MEMBER DETAILS

Scheme | Option | Membership Number

Title | Initials | First Names | Surname

Identity Number/ Passport Number | Date of Birth (Y Y Y Y M M D D) | E-mail Address

Postal Address

Street Number / Street Name
City
Suburb
Province / State
Code

Telephone Number (Home) code
Telephone Number (Work) code
Fax Number code
Cellphone Number

C. PATIENT DETAILS *(Beneficiary who requires Chronic Medication)*

Title | Initials | First Names | Surname

Identity Number | Date of Birth (Y Y Y Y M M D D)

Telephone Number (Home) code | Telephone Number (Work) code | Fax Number code

Cellphone Number | E-mail Address

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

Patient Name: ID Number:

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 dependant) 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 minor 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 beneficiary'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.
- The Scheme and its Administrator 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 Name (or member if patient is a minor)

Signature:

Date: Y Y Y Y M M D D

Clinical Information Consent Section

*You give permission to make **clinical information** available to the third party/family member specified below.*

Title | Initials | First Names | Surname | Relationship

Identity/Passport Number | Contact Number

Print Name and Surname of Patient

Signature:

Date: Y Y Y Y M M D D

E. CLINICAL CRITERIA

The following information is required when applying for a new chronic condition.

Certain conditions which do not appear on the form below may be considered for approval on the Chronic Benefit, although not all long-term conditions, which a doctor may define as chronic, will fulfill the criteria for approval.

** Chronic conditions only available on certain options of Suremed Health.*

Condition	Requirements
Addison's Disease	1. Initial Specialist Application. 2. ACTH Stimulation Test. 3. Serum Cortisol Test.
Ankylosing Spondylitis*	1. Initial Specialist Application.
Asthma	1. Lung function test (8 years of age and older).
Bipolar Mood Disorder	1. Specialist to complete Section K.
Asthma	1. Lung function test (8 years of age and older).
Bronchiectasis	1. Initial Specialist Application. 2. Attach relevant radiology report.
Cardiac failure	1. Specialist to complete section G.
Cardiomyopathy	1. Initial Specialist Application.
Chronic Obstructive Pulmonary Disease	1. Lung function test including FEV1/FVC and FEV1 post bronchodilator.
Chronic Renal Disease	1. Initial Specialist (Nephrologist) Application. 2. Serum Urea, Creatinine and GFR.
Coronary Artery Disease	1. Stress ECG confirming diagnosis. 2. Attach history of previous cardiovascular disease event(s).
Crohn's Disease	1. Initial Specialist Application. 2. Diagnostic reports to be supplied
Depression*	1. Prescriber to complete Section K.
Diabetes Insipidus	1. Initial Specialist Application. 2. Water deprivation test results.

Patient Name: ID Number:

Condition	Requirements
Diabetes Mellitus	1. Prescriber to complete Section G and H. 2. Please attach the diagnostic Fasting/Random Blood Glucose results *The application cannot be reviewed if this is not completed.* *The Scheme subscribes to the LifeSense Diabetic Management programme for the Navigator and Challenger options.*
Dysrhythmias	1. Prescriber to clearly indicate ICD-10 code. 2. ECG confirming diagnosis.
Epilepsy	1. EEG report confirming diagnosis. 2. Attach detailed seizure history.
Glaucoma	1. Initial Specialist Application. 2. Supply initial diagnostic intra-ocular pressure/s.
Haemophilia	1. Initial Specialist Application. 2. Haemophilia A (Factor VIII as % of Normal). 2. Haemophilia B (Factor IX as % of Normal).
HIV & AIDS	1. The Scheme subscribes to the LifeSense AIDS Management programme for the Navigator and Challenger options. *Please call 0860 506 080 for further information.*
Hyperlipidaemia	1. Prescriber to complete Section G and J. 2. Please attach the diagnosing Lipogram. *The application cannot be reviewed if this is not submitted.*
Hypertension	1. Prescriber to complete Section G and I. 2. Initial Specialist Application if younger than 18 years of age.
Hyperthyroidism	1. Attach initial diagnostic report.
Hypothyroidism	1.Attach initial diagnostic report.
Multiple Sclerosis	1. Initial Specialist Application. 2. Comprehensive disease history. 3. Extended Disability Status score (EDSS).
Myasthena Gravis*	1. Initial Specialist application
Osteoporosis*	1. DEXA bone mineral density (BMD) scan and report on any additional risk factors.
Parkinson's Disease	1. Initial Specialist Application.
Rheumatoid Arthritis (RA)	1. Initial diagnostic test results confirming RA may be required where a "stepped therapy" approach has not been implemented. 2. Initial Specialist Application for Leflunomide and Specialist Motivation for Biologic DMARDs. 3. Baseline Disease Activity Scores.
Schizophrenia	1. Psychiatrist to complete Section K.
Systemic Lupus Erythematosus	1. Initial Specialist Application. 2. Comprehensive disease history
Ulcerative Colitis	1. Initial Specialist Application. 2. Diagnostic reports to be supplied

F. PATIENT HEALTH INFORMATION *(to be completed by doctor)*

Weight: kg Height: m Hip/Waist ratio: Smoker? ☐ YES ☐ NO Ave per day:

Exercise: Frequency times per week Intensity: ☐ Low ☐ Medium ☐ High

Current Blood Pressure mmHg Available Blood Glucose Result mmol/L ☐ Fasting ☐ Random

G. CARDIOVASCULAR *(to be completed by doctor when applying for hypertension, hyperlipidaemia or diabetes mellitus)*

Is microalbuminuria present? ☐ YES ☐ NO Is GFR less than 60ml/min? ☐ YES ☐ NO

Please indicate which of the following co-morbidities/risk factors apply to this patient?

☐ Peripheral arterial disease ☐ Nephropathy ☐ Retinopathy ☐ Heart Failure

☐ Left ventricular hypertrophy ☐ Chronic renal disease ☐ Cardiomyopathy ☐ Prior stroke/TIA

☐ Prior myocardial infarction ☐ Prior CABG ☐ Prior Stent ☐ Angina

If heart failure is present, please indicate classification below:

NYHA/ACC-AHA Classification: ☐ A ☐ B/I(Mild) ☐ C/II(Mild)-III(Moderate) ☐ D/IV(Severe)

H. DIABETES MELLITUS

Please attach the laboratory diagnostic Fasting or Random Blood Glucose results.
The application cannot be reviewed if this is not submitted.

Patient Name: | ID Number:

I. HYPERTENSION *(to be completed by doctor when applying for hypertension)*

Please supply two blood pressure readings, performed on two different occasions, before initiating drug therapy, for a newly diagnosed patient.

(1.) Date: Y Y Y Y M M D D | mmHg | (2.) Date: Y Y Y Y M M D D | mmHg

J. HYPERLIPIDAEMIA *(to be completed by doctor when applying for hyperlipidaemia)*

Please attach the diagnosing lipogram. The application cannot be reviewed if this is not submitted.

Is there a family history of early-onset arteriosclerotic disease? ☐ YES ☐ NO *If yes, please provide details below:*

Does the patient suffer from familial hyperlipidaemia? ☐ YES ☐ NO Has this been verified by an Endocrinologist? ☐ YES ☐ NO

If yes, please provide details below:

Please risk your patient as per the Framingham coronary prediction algorithm %

K. PSYCHIATRIC CONDITIONS *(to be completed doctor by when applying for psychiatric disorders)*

Please indicate DSM IV diagnosis

Please indicate number of relapses

L. MEDICAL PRACTITIONER DETAILS & ADDITIONAL NOTES

Surname | Initials | Practice Number

Speciality | Telephone Number (code) | Fax Number (code)

Cellphone Number | E-mail Address

The outcome of this application must be communicated to me via: ☐ Email address ☐ Fax number

MEDICAL PRACTITIONER ADDITIONAL NOTES:

Patient Name: | ID Number:

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

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

Name of Medical Practitioner: | Signature: | Date: Y Y Y Y M M D D

N. HOW THE CHRONIC BENEFIT WORKS

The Chronic Benefit includes cover for medication from a specified list of chronic conditions which is in accordance with the Scheme option. These conditions have been selected according to clinical and actuarial criteria.

Chronic Disease List - The Prescribed Minimum Benefit regulations require that medical schemes cover the diagnosis, medical management and medication for a specified list of 27 chronic conditions known as the Chronic Disease List. All such conditions meeting approval criteria will be authorised under the PMB Chronic Medication benefit.

Extended Chronic Disease List - A list of Extended chronic conditions covered on the Challenger option is available on the website www.suremedhealth.co.za