

Chronic Illness Benefit application form 2012

This application form is to apply for the Chronic Illness Benefit and is only valid for 2012

Contact us

Tel: 0860 627 633, PO Box 652509, Benmore, 2010, www.nasmed.com

The latest version of the application form is available on www.nasmed.com. Alternatively members can phone 0860 627 633 and health professionals can phone 0860 44 55 66.

What you must do

Please go through these steps:

- Step 1:** Fill in and sign the application form (section 1), and fill in your details on the top of pages 4, 5, 6, 7 and 8.
Step 2: Take the application form to your doctor to complete and sign Section 2 and other relevant information/sections.
Step 3: Fax the completed application form to **011 539 7000**, email it to **CIB_APP_FORMS@discovery.co.za** or post it to Naspers Medical Fund, CIB Department, PO Box 652509, Benmore, 2010.

Naspers Medical Fund has the right to change the rules for membership from time to time. You may ask us for a copy of them at any time. When you sign this application, you confirm that you have read and understood the rules and that you agree that you and those you apply for will be bound by them.

If you have any questions, please contact Naspers Medical Fund on 0860 627 633. Once Discovery Health (Pty) Ltd have assessed your application, they will let you know of the outcome.

1. Patient's details

Name and surname

DOB/ID number

Membership number

Telephone Fax

Cellphone

Email

Outcome of this application must be sent to me by Email Fax

Date

Patient's signature (if patient is a minor, main member to sign)

I acknowledge that I have read and understood the conditions under "Patient Agreements" on page 2.

2. Doctor's details

Name and surname

BHF practice number

Speciality

Telephone Fax

Email

Outcome of this application must be sent to me by Email Fax

Patient Agreements

I give permission for my doctor to provide Naspers Medical Fund with my diagnosis and other relevant clinical information required to review my application for the Chronic Illness Benefit.

I understand that:

1. Funding from the Chronic Illness Benefit is subject to meeting benefit entry requirements as determined by Naspers Medical Fund.
2. The Chronic Illness Benefit provides cover for disease-modifying therapy only, which means that not all medicines for a listed condition are automatically covered by the Chronic Illness Benefit
3. By registering for the Chronic Illness Benefit, I agree that my condition may be subject to disease management interventions and periodic review and that this may include access to my medical records. I understand that not agreeing to this may lead to the withdrawal of this benefit.
4. Funding for medicine from the Chronic Illness Benefit will only be effective from when Naspers Medical Fund receives an application form that is completed in full.
5. I may need to send an updated or new application form, if the Chronic Illness Benefit department asks for this.

I consent to Naspers Medical Fund disclosing, from time to time, information supplied to Naspers Medical Fund (including general or medical information that is relevant to my application) to my healthcare provider, to administer my Chronic Illness Benefit. I agree that Naspers Medical Fund may disclose this information at its discretion, but only as long as all the parties involved have agreed to keep the information confidential.

3. The Prescribed Minimum Benefits (PMB)

For information only. Do not fax this page to Naspers Medical Fund. Naspers Medical Fund covers the following Prescribed Minimum Benefit Chronic Disease List (CDL) conditions, in line with legislation on all plan options.

PMB condition	Benefit entry criteria requirements
Addison's disease	Application form must be completed by a paediatrician (in the case of a child), endocrinologist or specialist physician
Asthma	Please attach a lung function test (LFT) report which includes the FEV1 post bronchodilator use for patients who are diagnosed at >50 years of age
Bipolar Mood Disorder	Application form must be completed by a psychiatrist
Bronchiectasis	Application form must be completed by a paediatrician (in the case of a child), pulmonologist or specialist physician
Cardiac failure	None
Cardiomyopathy	None
Chronic obstructive pulmonary disease (COPD)	1. Please attach a lung function test (LFT) report which includes the FEV1/FVC and FEV1 post bronchodilator use 2. Please attach a motivation from a specialist when applying for oxygen including: a. oxygen saturation levels off oxygen therapy b. number of hours of oxygen use per day
Chronic renal disease	1. Application form must be completed by a nephrologist or specialist physician 2. Please attach a diagnosing laboratory report reflecting creatinine clearance
Coronary artery disease	Please provide details of history of previous cardiovascular disease or event(s) in patient, if applicable
Crohn's disease	Application form must be completed by a gastroenterologist or specialist physician
Diabetes insipidus	Application form must be completed by an endocrinologist
Diabetes Type 1	None
Diabetes Type 2	Section 8 of this application form must be completed by the doctor
Dysrhythmias	None
Epilepsy	Application form for newly diagnosed patients must be completed by a neurologist, specialist physician or paediatrician (in the case of a child)
Glaucoma	Application form must be completed by an ophthalmologist
Haemophilia	Please attach a laboratory report reflecting factor VIII or IX levels
HIV and AIDS (antiretroviral therapy)	Please do not complete this application form for cover for HIV and AIDS. To enrol or request information on our HIVCare programme, please call 0860 627 633
Hyperlipidaemia	Section 6 must be completed by the doctor
Hypertension	Section 5 must be completed by the doctor
Hypothyroidism	Section 7 must be completed by the doctor
Multiple sclerosis (MS)	1. Application form must be completed by a neurologist 2. Please attach a report from a neurologist for applications for beta interferon indicating: a. Relapsing – remitting history b. All MRI reports c. Extended disability status score (EDSS)
Parkinson's disease	Application form must be completed by a neurologist or specialist physician
Rheumatoid arthritis	Application form must be completed by a rheumatologist, specialist physician or paediatrician (in the case of a child)
Schizophrenia	Application form must be completed by a psychiatrist
Systemic lupus erythematosus	Application form must be completed by a rheumatologist, nephrologist or specialist physician
Ulcerative colitis	Application form must be completed by a gastroenterologist or specialist physician

4. The Additional Disease List (ADL) conditions covered on the N Option Plus only (not covered by the Prescribed Minimum Benefits)

If you are on the N Option Plus Option you have cover for all the chronic conditions in the Additional Diseases List below. Your cover is subject to clinical entry criteria and your plan option.

ADL conditions covered on N Option Plus option	Benefit entry criteria
Alzheimer's disease	None
Attention deficit disorder (prescribed by a neurologist, paediatrician or psychiatrist)	Application form must be completed by a paediatrician, psychiatrist or neurologist.
Allergic rhinitis (where it forms part of a patient's asthma treatment)	None
Chronic back problems	None
Clinical depression (if treated by a psychiatrist)	Application must be completed by a psychiatrist.
Cystic fibrosis	Application must be completed by a pulmonologist or paediatrician (in the case of a child)
Endometriosis (limited to six month's treatment)	None
Gastro oesophageal reflux	Applications from GPs will be approved for six months pending a motivation from a gastroenterologist or surgeon.
Gout	None
Malabsorption	None
Organ transplantation	Application must be completed by a specialist.
Osteoporosis (bone density test required)	<ol style="list-style-type: none"> 1. All applications must be accompanied by a DEXA bone mineral density scan (BMD) Report 2. Endocrinologist motivation required in females < 30 years, males and children 3. Please attach information on additional risk factors in patient, where applicable 4. Please indicate if the patient sustained an osteoporotic fracture
Peripheral vascular disease	None
Psoriasis	None

*You cannot use this form to apply for biologics (Revellex®, Enbrel®, Humira®, Mabthera®)
Call 0860 627 633 or visit www.nasmed.com to request the relevant application form which must be completed by a rheumatologist.

Patient's name and surname

Membership number

5. Application for hypertension (to be completed by doctor)

Please note: For patients with refractory hypertension who may require more than three classes of medicines, the application should be completed by a specialist physician, cardiologist, paediatrician, nephrologist or endocrinologist.

A. Previously diagnosed patients

Was the diagnosis made more than six (6) months ago and has the patient been on treatment for at least that period of time? Yes

B. Please indicate if your patient has any of these condition(s)

- | | | | |
|-----------------------------|--------------------------|-----------------------|--------------------------|
| Chronic renal disease | <input type="checkbox"/> | Stroke/TIA | <input type="checkbox"/> |
| Hypertensive retinopathy | <input type="checkbox"/> | Angina | <input type="checkbox"/> |
| Prior CABG | <input type="checkbox"/> | Myocardial infarction | <input type="checkbox"/> |
| Peripheral arterial disease | <input type="checkbox"/> | Pre-eclampsia | <input type="checkbox"/> |

C. Newly diagnosed patients

Diagnosis made within the last six (6) months:

Please note: Specialist physician, cardiologist, paediatrician, nephrologist or endocrinologist application is required if the patient is younger than 30 years old, as recommended in the "SA Hypertension Guidelines".

Blood pressure \geq 130/85 mmHg and patient has diabetes or congestive cardiac failure or cardiomyopathy Yes
OR

Blood pressure \geq 160/100 mmHg Yes
OR

Blood pressure \geq 140/90 mmHg on two or more occasions, despite lifestyle modification for at least 6 months Yes
OR

Blood pressure \geq 130/85 mmHg and the patient has target organ damage indicated by Yes

- Left ventricular hypertrophy or
- Microalbuminuria or
- Elevated creatinine

Patient's name and surname

Membership number

6. Application for hyperlipidaemia (to be completed by doctor)

If the patient meets the requirements listed in either A, B or C below, hyperlipidaemia will be approved for funding from the Chronic Illness Benefit. Information provided in section D will be reviewed on an individual basis. We may request and review the member's information retrospectively.

A. Primary prevention

Please **attach the diagnosing lipogram**, and confirm that the following secondary causes have been excluded and supply the results:

Hypothyroidism	TSH:
Diabetes Type 2	Fasting glucose:
Alcohol excess (where applicable)	gamma-GT:
Drug-induced hyperlipidaemia	Yes <input type="checkbox"/> No <input type="checkbox"/>

Please supply the patient's current blood pressure reading _____ / _____ mmHg

Is the patient a smoker (defined as any cigarette smoking in the last month or a history of 20 cigarettes a day for 10 years)?

Yes No

Please give details of family history of major cardiovascular events:

	Father	Mother	Brother	Sister
Treatment or event details				
Age at time of diagnosis or event				

Please use the Framingham 10-year risk Assessment Chart to determine the absolute 10-year risk of a coronary event (NH publication no. 01-3670; May 2001)

Does the patient have a risk of 20% or greater

Yes

OR

Is the risk 30% or greater when extrapolated to age 60

Yes

B. Familial hyperlipidaemia

Please attach the diagnosing lipogram

Patient has had diagnosis of homozygous familial hyperlipidaemia confirmed by an endocrinologist or lipidologist.
Please attach supporting documentation.

Yes

OR

Patient has had diagnosis of heterozygous familial hyperlipidaemia confirmed by a specialist.
Please attach supporting documentation and complete the section below.

Yes

Please give details of family history of major cardiovascular events:

	Father	Mother	Brother	Sister
Treatment or event details				
Age at time of diagnosis or event				

Please detail signs of familial hyperlipidaemia in this patient:

C. Secondary prevention

Please indicate what condition(s) your patient has:

Diabetes Type 2	<input type="checkbox"/>	Ischaemic heart disease	<input type="checkbox"/>
Intermittent claudication	<input type="checkbox"/>	Nephrotic syndrome and chronic renal failure	<input type="checkbox"/>
Prior CABG	<input type="checkbox"/>	Diabetes Type 1 with microalbuminuria	<input type="checkbox"/>
Stroke/TIA	<input type="checkbox"/>	Any vasculitides where there is associated renal disease	<input type="checkbox"/>

Patient's name and surname

Membership number

6. Application for hyperlipidaemia (to be completed by doctor) (continued)

D. Please supply any other relevant clinical information about this patient that supports the use of a lipid lowering drug:

7. Application for hypothyroidism (to be completed by doctor)

If the patient meets the requirements listed in either A or B below, hypothyroidism will be approved for funding from the Chronic Illness Benefit. We may request and review the member's information retrospectively.

A. **Thyroidectomy** *Please indicate whether your patient has had a thyroidectomy* Yes

B. **Please attach the initial or diagnostic laboratory results that confirm the diagnosis of hypothyroidism, including TSH and T4 levels**

Was the diagnosis based on the presence of clinical symptoms and one of the following?

A raised TSH and reduced T4 level Yes

OR

A raised TSH but normal T4 and higher than normal thyroid antibodies Yes

OR

A raised TSH level of greater than or equal to 10 on two or more occasions at least three months apart in a patient with normal T4 and clinical symptoms Yes

8. Application for diabetes type 2 (to be completed by doctor)

If the patient meets the requirements listed in either A or B below, diabetes type 2 will be approved for funding from the Chronic Illness Benefit. We may request and review the member's information retrospectively.

A. **Please attach the initial or diagnostic laboratory results that confirm the diagnosis of diabetes type 2**

Please note that finger prick and point of care tests are not accepted for registration on the Chronic Illness Benefit.

Do these results show?

A fasting plasma glucose concentration ≥ 7.0 mmol/l Yes

OR

A random plasma glucose ≥ 11.1 mmol/l Yes

OR

Was the two hour post-glucose ≥ 11.1 mmol/l during an oral glucose tolerance test (OGTT) Yes

B. **Is the patient a type 2 diabetic on insulin** Yes

Patient's name and surname

Membership number

Medicine required (to be completed by doctor)

Formulary medicine will be paid at the Fund Medicine rate. There will be no co-payment for medicine selected from the formulary.

ICD-10	Diagnosis description	Date when condition was first diagnosed	Medicine name, strength and dosage	How long has the patient used this medicine?		May a generic medicine be used?	
				Years	Months	Yes	No

Notes to doctors

1. The doctor's fee for completion of this form will be reimbursed on code 0199, on submission of a separate claim. Payment of the claim is from the day-to-day benefits (if applicable to the member's plan option), subject to the Fund rules and availability of funds and where the member is a valid and active member at the service date of the claim.
2. In line with legislative requirements, please ensure that when using code 0199, you submit the ICD-10 diagnosis code(s). As per industry standards, the appropriate ICD-10 code(s) to use for this purpose would be those reflective of the actual chronic condition(s) for which the form was completed. If applying for cover for multiple chronic conditions, it would be appropriate to list all the relevant ICD-10 codes.
3. You may call 0860 44 55 66 for **changes** to your patient's medicine for an **approved** condition.
4. An application form only needs to be completed when applying for a **new chronic condition**.
5. If you have a clinical issue that you need to discuss with a doctor or pharmacist, please call 0860 44 55 66 or email CIB_APP_FORMS@discovery.co.za

Doctor's signature

Date

Patient's name and surname

Membership number

Exception requests

Please complete the table below where non-formulary medicine is prescribed for the treatment of PMB CDL conditions and the request is for cover without co-payment. Please supply a clinical motivation and supporting documentation where appropriate, as to why the formulary medicine cannot be used by the patient, including details of treatment failure or adverse drug reactions where applicable.

Details of medicine to be paid without co-payment

Medicine name and strength	Quantity	Is the patient controlled? (Please attach relevant details)

Previous medicine history

Medicine name	Date medicine started	Length of therapy	Details of treatment failure or adverse effects

Doctor's signature

Date