

Contact details

Tel: 0860 11 33 22, PO Box 652509, Benmore 2010, www.discovery.co.za

Chronic Illness Benefit application form 2017

This application form is to apply for the Chronic Illness Benefit and is only valid for 2017

The latest version of the application form is available on www.discovery.co.za. Alternatively members can phone 0860 11 33 22 and health professionals can phone 0860 44 55 66.

Who we are

The University of KwaZulu-Natal Medical Scheme (referred to as 'the Scheme'), registration number 1520, is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Scheme.

How to complete this form

- Step 1:** Fill in and sign the application form (section 1), and fill in your details on the top of page 4, 5, 6 and 7.
- Step 2:** Take the application form to your doctor to complete section 2, other relevant sections and sign section 9. Any additional information requested in these sections should be sent with this form.
- Step 3:** Fax the completed application form to **011 539 7000**, email it to **CIB_APP_FORMS@discovery.co.za** or post it to University of KwaZulu-Natal Medical Scheme, CIB Department, PO Box 652919, Benmore, 2010.

If you have any questions, please let us know. Once we have assessed your application, we will let you know.

1. Patient's details

Name and surname

ID/Date of birth

Membership number

Telephone Fax

Cellphone

Email

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

Member's acceptance and permission

I give permission for my healthcare provider to provide University of KwaZulu Natal Medical Scheme and Discovery Health (Pty) Ltd with my diagnosis and other relevant clinical information required to review my application. I agree to my information being used to develop registries. This means that you give permission for us to collect and record information about your condition and treatment. This data will be analysed, evaluated and used to measure clinical outcomes and make informed funding decisions.

I understand that:

- 1.1 Funding from the Chronic Illness Benefit is subject to meeting benefit entry criteria requirements as determined by University of KwaZulu-Natal Medical Scheme.
- 1.2 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.
- 1.3 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.
- 1.4 Funding for medicine from the Chronic Illness Benefit will only be effective from when University of KwaZulu-Natal Medical Scheme receives an application form that is completed in full.
- 1.5 I may need to send an updated or new application form, if the Chronic Illness Benefit department asks for this.
- 1.6 Payment for completion of this form, on submission of a claim, is subject to KwaZulu-Natal Medical Scheme rules and where I am a valid and active member at the service date of the claim.

I consent to University of KwaZulu-Natal Medical Scheme and Discovery Health (Pty) Ltd disclosing, from time to time, information supplied to University of KwaZulu-Natal Medical Scheme and Discovery Health (Pty) Ltd (including general or medical information that is relevant to my application) to my healthcare provider, to administer my Chronic Illness Benefit. I agree that University of KwaZulu-Natal Medical Scheme and Discovery Health (Pty) Ltd may disclose this information at its discretion, but only as long as all the parties involved have agreed to keep the information confidential.

Date

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

2. Doctor's details

Name and surname

BHF practice number

Specialty

Telephone Fax

Email

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

3. The Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions covered on University of KwaZulu-Natal Medical Scheme

University of KwaZulu-Natal Medical Scheme covers the following Prescribed Minimum Benefit Chronic Disease List conditions, in line with legislation.

Chronic disease list 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	None
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 that includes the FEV1/FVC 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	None
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 100 417
Hyperlipidaemia	Section 6 of this application form must be completed by the doctor
Hypertension	Section 5 of this application form must be completed by the doctor
Hypothyroidism	Section 7 of this application form 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 including: 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, pulmonologist 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, pulmonologist 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 University of KwaZulu-Natal Medical Scheme

Your cover is subject to benefit entry criteria.

Additional disease list condition	Benefit entry criteria requirements
Attention deficit hyperactivity disorder	Application form must be completed by a psychiatrist, neurologist or paediatrician
Chronic anxiety disorders	Application form must be completed by a psychiatrist
Chronic dyspepsia	Application form must be completed by a gastroenterologist, general surgeon or paediatrician (in the case of a child)
Chronic rhinitis	None
Chronic sinusitis	None
Chronic vertigo	None
Collagen disease	None
Dementias	Application form must be completed by a psychiatrist, neurologist or specialist physician
Depression	Applications for 1st line therapy will be accepted from GPs for 6 months only. Psychiatrist motivation is required for further cover
Eczema	None
Gout	None
Motor neurone disease	None
Neurogenic bladder	None
Osteoarthritis	None
Psoriasis	None
Recurrent cystitis	None
Spastic colon	None
Vascular headaches	None

Patient's name and surname

Membership number

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

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

A. Previously diagnosed patients

Was the diagnosis made more than six 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 conditions:

- | | | | |
|-----------------------------|--------------------------|-----------------------|--------------------------|
| Chronic renal disease | <input type="checkbox"/> | 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"/> |
| Stroke | <input type="checkbox"/> | | |

C. Newly diagnosed patients

Diagnosis made within the last six months.

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 six 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, C or E 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 or has the patient ever been a smoker? 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 (NIH 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

Was the patient diagnosed with homozygous familial hyperlipidaemia and was the diagnosis confirmed by an endocrinologist or lipidologist? Yes

Please attach supporting documents.

OR

Was the patient diagnosed with heterozygous familial hyperlipidaemia and was the diagnosis confirmed by a specialist? Yes

Please attach supporting documents and complete the section below.

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 conditions 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	<input type="checkbox"/>	Any vasculitides where there is associated renal disease	<input type="checkbox"/>
TIA	<input type="checkbox"/>		

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

E. Was the patient diagnosed with hyperlipidaemia more than five years ago and the laboratory results are not available? Yes

Patient's name and surname

Membership number

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

If the patient meets the requirements listed in either A, B, C, D or E 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. Radioactive iodine** Please indicate whether your patient has been treated with radioactive iodine Yes
- C. Hashimoto's thyroiditis** Please indicate whether your patient has been diagnosed with Hashimoto's thyroiditis Yes
- D. 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 Yes
- E. Was the patient diagnosed with hypothyroidism more than five years ago and the laboratory results are not available?** Yes

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

If the patient meets the requirements listed in either A, B or C 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
- A two hour post-glucose ≥ 11.1 mmol/l during an oral glucose tolerance test (OGTT) Yes
- OR
- An HbA1C $\geq 6.5\%$ Yes
- B. Is the patient a type 2 diabetic on insulin?** Yes
- C. Was the patient diagnosed with diabetes type 2 more than five years ago and the laboratory results are not available?** Yes

Important: Please note that no exceptions will be made for patients being treated with Metformin monotherapy.

Patient's name and surname

Membership number

9. Medicine required (to be completed by doctor)

Formulary medicine will be funded up to the Scheme Rate for Medicine. There will be no co-payment for medicine selected from the formulary. For non-formulary medicine, we fund up to the Chronic Drug Amount (CDA), which is a monthly amount we pay up to, for a specific medicine class. The member may be liable for a co-payment where the cost of the medicine is greater than the CDA.

ICD-10	Diagnosis description	Date when condition was first diagnosed	Medicine name, strength and dosage	How long has the patient used this medicine?	
				Years	Months

Notes to doctors

- 9.1 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 subject to University of KwaZulu-Natal Medical Scheme rules and where the member is a valid and active member at the service date of the claim.
- 9.2 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 funding for multiple chronic conditions were applied for, then it would be appropriate to list all the relevant ICD-10 codes.
- 9.3 We will approve funding for generic medicine, where available, unless you have indicated otherwise.
- 9.4 Please submit all the requested supporting documents with this application to prevent delays in the review process.
- 9.5 You may call 0860 44 55 66 for **changes** to your patient's medicine for an **approved** condition. An application form only needs to be completed when applying for a **new chronic condition**.

Doctor's signature

Date