Contact us
Tel: 0860 222 999, PO Box 652509, Benmore, 2010, www.altronmedicalaid.co.za

Chronic Illness Benefit application form 2010

This application form is to apply for the Chronic Illness Benefit and is only valid for 2010.

The latest version of the application form is available on www.altronmedicalaid.co.za. Alternatively members can phone 0860 222 999 and health professionals can phone 0860 44 55 66.

Fax the completed application form to 011 539 7000, email it to CIB_APP_FORMS@discovery.co.za
or post it to Altron Medical Aid, CIB Department, PO Box 652919, Benmore, 2010.

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 page 4 and 5.

Step 2: Take the application form to your doctor.

The Scheme 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 let us know. Once we have assessed your application, we will let you know.

1. Important patient information (to be completed by the member)

Title ☐☐☐☐ Surname ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

First name(s) ☐☐

Sex M☐ F☐ Identity number ☐☐☐☐☐☐☐☐☐☐☐☐☐ Member number ☐☐☐☐☐☐☐☐☐☐☐☐☐

Telephone (H) ☐☐☐☐☐ ☐☐☐☐☐☐☐ (W) ☐☐☐☐☐ ☐☐☐☐☐☐☐

Cellphone ☐☐☐ ☐☐☐☐☐☐☐ Fax ☐☐☐☐☐ ☐☐☐☐☐☐☐

Email ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

The outcome of this application can be communicated to me by email Yes ☐ No ☐ or fax number Yes ☐ No ☐

I give permission for my doctor to provide Altron Medical Aid 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 clinical entry criteria and drug utilisation review as determined by Altron Medical Aid
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 doing this may lead to the withdrawal of this benefit
4. medicine approved by the Chronic Illness Benefit will only be effective from when Altron Medical Aid receives an application form that is completed in full
5. the covered Chronic Illness Benefit conditions and clinical entry criteria may change from time to time and I may need to send an updated or new application form, if the Chronic Illness Benefit department asks for this.

By signing this, I also give my consent that Altron Medical Aid may, from time to time, disclose any information supplied to them – including general or medical information or any other third party. I agree that the Scheme may disclose this information at its sole discretion, but only as long as all the parties involved have agreed to keep the information confidential at all times.

Main member's signature ☐ Patient (unless a minor) ☐

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2. The Prescribed Minimum Benefits (PMB) (for members on all plan types)

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

PMB condition	Clinical entry criteria requirements
Addison's disease	Application form must be completed by a paediatrician or endocrinologist
Asthma	The South African Treatment Guidelines for Asthma, as published in the South African Medical Journal are applied to all applications
Bipolar Mood Disorder	Application form must be completed by a psychiatrist
Bronchiectasis	Application form must be completed by a paediatrician or pulmonologist
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. 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.
Diabetes insipidus	Application form must be completed by an endocrinologist
Diabetes Type 1	None
Diabetes Type 2	Refer to section 6 of this application form
Dysrhythmias	None
Epilepsy	Application form 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 HIV*Care* programme, please call 0860 100 417.
Hyperlipidaemia	Section 5 must be completed by the doctor
Hypertension	Section 4 must be completed by the doctor
Hypothyroidism	1. Please attach the initial or diagnostic laboratory report that confirms the diagnosis of hypothyroidism, including TSH and T4 blood levels. 2. Please indicate if the patient had a thyroidectomy.
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
Rheumatoid arthritis	1. Application must be completed by a rheumatologist, specialist physician or paediatrician (in the case of a child) 2. Application for COXIBs must be accompanied by a motivation for its use over conventional anti-inflammatories
Schizophrenia	Application form must be completed by a psychiatrist
Systemic lupus erythematosus	Application form must be completed by a rheumatologist or nephrologist
Ulcerative colitis	Application form must be completed by a gastroenterologist
The conditions below were previously incuded in the Additional Disease List (ADL) but are now listed separately as they are covered on all plan types.	
Cushing's disease	Refer to Pituitary disorders
Hypoparathyroidism	Application form must be completed by an endocrinologist or paediatrician (in the case of a child)
Organ transplantation	Application must be completed by a specialist
Paraplegia	None
Pemphigus	Application must be completed by a dermatologist or paediatrician
Peripheral arteriosclerotic disease	Application must be completed by a cardiologist or neurologist
Pituitary disorders	Application form must be completed by an endocrinologist, neurologist or paediatrician (in the case of a child) Cover includes, but is not limited to, the following conditions: Cushing's disease, acromegaly and hyperprolactinaemia
Quadriplegia	None
Stroke	None
Thrombocytopaenia purpura	Application must be completed by a specialist
Valvular heart disease	Application must be completed by a cardiologist

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3. The Additional Disease List (ADL) conditions covered on the Enhanced Option (not covered by the Prescribed Minimum Benefits)

Additional disease list	Clinical entry criteria requirements
Acne	Script required from endoctinologist or dermatologist
ADHD (in children)	
Allergic rhinitis	
Benign prostatic hypertrophy	
Cancer	
Chronic depression	
Chronic hepatitis	
Cystic fibrosis	
GORD	
Gout	
Hormone replacement therapy	
Obsessive Compulsive Disorder	
Osteoarthritis	
Motor neuron disease	Application must be completed by a psychiatrist
Osteoporosis	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
Paget'sdisease	Application must be completed by a specialist physician or paediatrician
Psoriasis	

* This application form is not applicable for applications for biologics (Revellex®, Enbrel®, Humira®, Mabthera®)
Call 0860 222 999 or visit www.altronmedicalaid.co.za to request the relevant application form which must be completed by a rheumatologist.
Please note that biologics are only covered on Executive and Comprehensive Plans

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Patient's name and surname | | | | | | | | | | | | | | | Membership number | | | | | | | | | | | | |

4. Application for hypertension (to be completed by the doctor)

- This section must be completed for all patients applying for hypertension.
- A specialist must complete this section for patients with hypertension who are younger than 30 years of age. This is in line with the South African Treatment Guidelines for hypertension.

1. Patient's weight in kg ☐☐☐ Patient's height in metres ☐☐☐
2. When did this patient commence drug therapy for hypertension? Y Y Y Y M M D D
3. For hypertension **diagnosed in the last six months and all newly diagnosed patients,** please supply two initial blood pressure readings (before drug therapy commenced) done at least two weeks apart in order to determine the stage of hypertension.

   i) ________/__________ mmHg Date Y Y Y Y M M D D

   ii) ________/__________ mmHg Date Y Y Y Y M M D D

4. Current blood pressure reading (for all patients) ________/________ mmHg

Does the patient have target organ damage or any of the associated conditions as listed below. Tick relevant conditions below.

Left ventricular hypertrophy	☐	Stroke/TIA	☐	Hypertensive retinopathy	☐
Angina	☐	Chronic renal disease	☐	Prior CABG (coronary artery bypass graft)	☐
Myocardial infarction	☐	Peripheral arterial disease	☐	Heart failure	☐

5. Application for hyperlipidaemia (to be completed by the doctor)

Primary hyperlipidaemia

Please attach diagnosing lipogram.

The Scheme will fund medicine for patients with an absolute 10 year risk of a coronary event of 20% or more. This is in line with the Council for Medical Scheme's Algorithm.

1. Patient's weight in kg ☐☐☐ Patient's height in metres ☐☐☐
2. Does the patient smoke? Yes ☐ No ☐
3. Family history (Please complete the table below for primary and familial hyperlipidaemia)

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

4. Current blood pressure reading (for all patients) ________/________ mmHg

Please note: The following questions need to be answered for the application to be processed for primary hyperlipidaemia

Have secondary causes been excluded? Yes ☐ No ☐

Please supply the following results:

a) Hypothyroidism	TSH:
b) Diabetes mellitus	Fasting glucose:
c) Alcohol excess (where applicable)	gamma-GT:
d) Drug induced dyslipidaemia?	Yes ☐ No ☐

Familial hyperlipidaemia

Please attach the diagnosing lipogram. Please complete the family history table above (5.3)

Please indicate any signs of familial hyperlipidaemia in this patient.

Secondary prevention

Please indicate what condition(s) your patient has:

Type 1 diabetes with microalbuminuria (please submit supporting clinical reports) ☐

Any of the vasculitides, for example SLE where there is associated renal disease ☐

Type 2 diabetes	☐	Intermittent claudication	☐	Nephrotic syndrome and chronic renal failure	☐
Prior CABG	☐	Stroke/TIA	☐	Ischaemic heart disease	☐

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Patient's name and surname | | Membership number |

6. Application for type 2 diabetes

1. Please attach a laboratory report that confirms the diagnosis of type 2 diabetes.
2. The Chronic Illness Benefit will fund medicine for type 2 diabetes if the criteria for the diagnosis of this condition are met based on the SEMDSA Guidelines.
3. The specific criteria are:
   - Fasting plasma glucose concentration ≥ 7.0 mmol/l
   - Random plasma glucose ≥ 11.1 mmol/l
   - Two hour post-glucose ≥ 11.1 mmol/l during an Oral Glucose Tolerance Test (OGTT)
4. Please note that based on cost and clinical guidelines, applications for glitazones and nateglinide require a motivation for use over conventional therapy from a specialist physician or endocrinologist.

7. Current medicine required (to be completed by the doctor)

Note to member and doctor: The Chronic Illness Benefit application requirements (tests, motivations, supporting documentation or completion by a specialist) are indicated in section 2 and 3 of this application form. Please read and submit the documentation relevant to the condition you are applying for.

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
		YYYYMMDD					
		YYYYMMDD					
		YYYYMMDD					
		YYYYMMDD					
		YYYYMMDD					
		YYYYMMDD					

8. Doctor's details and signature (to be completed by the doctor)

Name

BHF practice number

Telephone (W) | Fax

Email

Speciality ______________________

Doctor's signature ______________________ Date YYYYMMDD

The outcome of this application must be communicated to me by email Yes ☐ No ☐ or fax Yes ☐ No ☐

Note to doctors:

- **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 Savings Account (if applicable to the member's plan type), subject to Scheme rules and availability of funds.**
- 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 multiple chronic conditions were applied for, then it would be appropriate to list all the relevant ICD-10 codes.
- You may call 0860 222 999 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.**

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