Physical address Allcare House, 90 Grayston Drive, Sandton, 2196
Postal address PO Box 2650, Rivonia, 2128
Share Call 0860 10 96 96
Fax 011 783 2020 / 011 783 5096

hosmed
care for life

PMB CHRONIC DISEASE LIST CONDITIONS (CDL)
To comply with the Risk Equalisation Fund (REF) criteria and other chronic conditions

PLEASE PRINT IN CAPITAL LETTERS. USE PEN ONLY. PLEASE COMPLETE ONE APPLICATION FORM PER PATIENT.

SECTION A: MEMBER DETAILS

Member no.		Title: Mr / Mrs / Miss		Initials	
Name(s):		Surname			
Tel. no. (h)		(w)		(Cell)	
Email		Identity no.			
Language		Postal address			
				Postal code	

SECTION B: PATIENT DETAILS

Dependent code		Title: Mr / Mrs / Miss		Initials	
Name(s):		Surname			
Date of birth		Gender (please tick appropriate)	M F	Identity no.	
Tel. no. (h)		(w)		(Cell)	
Postal address (if different from member)					
				Postal code	

SECTION C: DOCTOR DETAILS

Initials		Surname			
Practice no.		Speciality			
Tel. no. (w)		(Fax)		(Cell)	
Email					

SECTION D: GENERAL INFORMATION

Clinical entry criteria for the PMB-CDL conditions to be completed by the treating physician:
In order for a patient /beneficiary to qualify for the PMB benefit and to fulfill the requirements of the Risk Equalisation Fund (REF), the medical practitioner must supply the relevant information per disease condition on the following pages.

Hosmed members are subject to the Mediscor formulary. The formulary level is determined by the scheme option chosen. The formulary can be viewed at www.mediscor.net

The attending medical practitioner's signature is required on each page to confirm the CDL condition together with the appropriate ICD-10 code. Failure to complete the application, with the relevant signatures from the patient and the treating physician, as well as providing the required information, will result in non-registration of the condition.

ATTENDING MEDICAL PRACTITIONER TO KINDLY COMPLETE THE RELEVANT SECTIONS AND RETURN ALL PAGES to
PO Box 8796, Centurion, 0046 or fax to 0866 151 508 or 0866 151 509 or email to preauth@mediscor.co.za

SECTION E: DECLARATION

I declare and understand that this application shall be null and void if any information supplied by me and/or my dependants should be false or incomplete. In which case I will repay all monies paid to me and/or my dependants (or on my behalf) by the scheme for benefits received for the treatment of any of the disease conditions ticked. I give my irrevocable consent to any medical doctor, person or organization that may possess, or come into possession of any medical information to disclose this information to the scheme, to the extent permitted by law.

_____

Signature (Principal Member):

Signed at _____ on this _____ day of _____ 20 _____

SECTION F: PATIENT DETAILS

Initials		Surname	
Member no.		Dependent code	

CARDIOVASCULAR DISEASES:

Disease	✓	ICD-10 code	Clinical entry criteria / remarks
Cardiac failure			
Cardiomyopathy			
Coronary artery disease			
Dysrhythmias			
Hypertension			
Hyperlipidaemia			BP reading: Height: Weight: Exercise: yes / no Smoking: yes / no Date of lipogram:
Lipogram reading:			
TCL:	LDL:		HDL: Triglycerides:
Risk factors: (please indicate where applicable)			
Family history		Hypertension	Angina/Myocardial infarction / Angioplasty/Stent
Cerebrovascular accident (CVA)		Transient Ischaemic attack	Peripheral vascular disease

ENDOCRINOLOGY:

Disease	✓	ICD-10 code	Clinical entry criteria / remarks
Addison's disease			
Diabetes insipidus			
Diabetes mellitus 1			
Diabetes mellitus 2			
Hypothyroidism			

RESPIRATORY DISEASES:

Disease	✓	ICD-10 code	Clinical entry criteria / remarks
Asthma			Mild intermittent / Mild persistent Moderate persistent / Severe persistent
Bronchiectasis			
Chronic obstructive pulmonary disease (COPD)			Stage 1 / Stage 2 / Stage 3 Initial FEV 1: (Spirometry report required):

AUTO IMMUNE DISEASES:

Disease	✓	ICD-10 code	Clinical entry criteria / remarks
Multiple sclerosis			*Please note that confirmation of diagnosis is required from a Neurologist Neurologist practice no.
Systemic lupus erythematosus			

Prescribing doctor's signature: Date

Patient signature: Date

SECTION G: PMB CONDITIONS

AUTO IMMUNE DISEASES: (Continued)

Disease	✓	ICD-10 code	Clinical entry criteria / remarks	
Rheumatoid arthritis			* Please tick the appropriate initial symptoms:	
			Morning stiffness lasting at least one hour before maximal improvement, for at least 6 consecutive weeks.	
			Soft tissue swelling or effusion, observed by a physician, in at least three of the following joint areas (right or left): proximal interphalangeal (PIP), metacarpophalangeal (MCP), wrist, elbow, knee, ankle or metatarsophalangeal (MTP) joints, for at least 6 consecutive weeks.	
			Swelling or effusion, observed by a physician, in the proximal interphalangeal, metacarpophalangeal, or wrist joints, for at least 6 consecutive weeks.	
			Symmetrical (right and left sides) swelling or fluid in the joints mentioned in point 2, observed by a physician, for at least 6 consecutive weeks.	
			Subcutaneous nodules over bony prominences or extensor surfaces, or in juxta articular regions, observed by a physician.	
			Demonstration of serum rheumatoid factor (RF) detected by any method that has been positive in less than 5% of control subjects.	
			Radiographic evidence in the hands or wrists of articular erosions or osteopenia in or around the affected joints.	

INFLAMMATORY BOWEL DISEASES:

Disease	✓	ICD-10 code	Clinical entry criteria / remarks
Crohn's disease			
Ulcerative colitis			

CENTRAL NERVOUS SYSTEM DISEASES

Disease	✓	ICD-10 code	Clinical entry criteria / remarks
Bipolar mood disorder			* Please note that confirmation of diagnosis is required from a Psychiatrist Psychiatrist Practice Number:
Epilepsy			
Parkinson's disease			

OTHER DISEASES:

Disease	✓	ICD-10 code	Clinical entry criteria / remarks
Chronic renal disease			*Glomerular filtration rate or creatinine clearance cerificate to be submitted.
Glaucoma			
Haemophilia			

Prescribing doctor's signature: _____ Date | | | | | | | | |

Patient signature: _____ Date | | | | | | | | |

HIV / AIDS

Please contact Lifesense Clinical Consultants to enrol on the disease management programme on 0860 50 60 80

ONCOLOGY

Please contact Allcare Administrators to enrol on the oncology programme on 011 290 6307

OTHER CHRONIC CONDITIONS

Please note: The following conditions may be reimbursed from the chronic benefit according to Hosmed scheme rules.
* Additional information may be required

Disease	✓	ICD-10 code	Clinical entry criteria / remarks
ADHD (in children)*			* Please note that confirmation of diagnosis is required from a Specialist Practice Number:
Allergic Rhinitis*			* Only if associated with asthma
Ankylosing spondylitis			
Chronic depression*			* Please supply DSM IV classification
Cystic Fibrosis			
Endocarditis prophylaxis			
Endometriosis			
Gastro oesophageal reflux disease*			* Please submit gastroscopy report
Hypoparathyroidism			
Menopause (Hormone replacement therapy)			
Organ transplant (immunosuppresants)			
Osteo-arthritis			
Osteoporosis*			* Please submit copy of Bone density report (dexa-scan)
Paget's disease			
Pituitary adenoma			
Prostatic hypertrophy (benign)			
Psoriasis			

MEDICINE PRESCRIBED :

Description	Dosage	Strength

Prescribing doctor's signature:

Date

Patient signature:

Date