



Administered by Discovery Health

Contact us

Tel: 0860 116 116, PO Box 652509, Benmore, 2010, www.yourremedi.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.yourremedi.co.za. Alternatively you can phone 0860 116 116, or your doctor 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 Discovery Health, CIB Department, PO Box 652919, Benmore, 2010.

What you must do

Step 1: Fill in and sign the application form (section 1), and fill in your details at the top of page 4 and 5.

Step 2: Take the application form to your doctor. Your doctor may call 0860 116 116 for changes to your medicine for an approved condition. An application form needs to be completed when applying for a new chronic condition.

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Remedi has the right to change the rules for membership from time to time. You may ask for a copy of these rules 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	<input type="text"/>	Surname	<input type="text"/>															
First name(s)	<input type="text"/>																	
Sex	<input type="checkbox"/> M <input type="checkbox"/> F	Identity number	<input type="text"/>										Member number	<input type="text"/>				
Telephone (H)	<input type="text"/>		<input type="text"/>					(W)	<input type="text"/>		<input type="text"/>							
Cellphone	<input type="text"/>		<input type="text"/>					Fax	<input type="text"/>		<input type="text"/>							
Email	<input type="text"/>																	

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 Discovery Health 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 Remedi
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. we will only be able to approve this application when we receive a fully completed form
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 permission that Remedi may, from time to time, disclose any information supplied to them – including general or medical information – to a third party. I agree that Remedi 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)

2. The Prescribed Minimum Benefits (PMB) (for members on all Benefit Options)

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

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
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 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 on or request information about our HIVCare 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
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 including Cushing's disease	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: acromegaly and hyperprolactinaemia
Quadriplegia	None
Stroke	None
Thrombocytopenia purpura	Application must be completed by a specialist
Valvular heart disease	Application must be completed by a cardiologist

3. Cover for conditions that are not Prescribed Minimum Benefit conditions. Remedi will not authorise cover from the Chronic Illness Benefit for the following conditions. (If your condition does not appear on the list below, you can apply for cover.)

Acute bacterial and viral infections	Halitosis
Alcoholic liver cirrhosis	Headaches; non-specific
Alopecia	Haemorrhoids
Backache	Hyperacidity, Indigestion – needs specific diagnosis not only symptoms
Constipation – unless diagnosis is Diverticular disease or as a consequence of chemotherapy	Hypotension
	Insomnia
Contraception	Irritable bowel syndrome
Dandruff, Seborrhea	Mastalgia
Dermatophytes, Oncomycosis, Dermatophytic onchia	Obesity
Diarrhoea	Oedema – allow in cases of cardio-vascular conditions
Disorders of the conjunctiva	Oral and vaginal thrush, Candida
Dysmenorrhoea, menorrhagia	Pain, non-specific
Dyspepsia	Restless legs, cramps
Dysuria	Senile dementia, cognitive dysfunction – exclude drugs such as Nootropil; Encaphabol; Reactivin
Erectile dysfunction	Sinusitis
Fever blisters	Solar keratosis
Fibromyalgia, Myalgia	Superficial fungal infections
Fibrositis	Unspecified cough
Flatulence	Urticaria
Folate deficiency	Varicose veins
Follicitis	

* This application form cannot be used to apply for biologics (Revellex®, Enbrel®, Humira®, Mabthera®). Call 0860 116 116 to get the relevant application form, which must be completed by a rheumatologist. Please note that biologics are covered at Remedi's discretion, based on certain criteria.

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?

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 to determine the stage of hypertension.

i) _____ / _____ mmHg Date

ii) _____ / _____ mmHg Date

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 | <input type="checkbox"/> | Stroke/TIA | <input type="checkbox"/> | Hypertensive retinopathy | <input type="checkbox"/> |
| Angina | <input type="checkbox"/> | Chronic renal disease | <input type="checkbox"/> | Prior CABG (coronary artery bypass graft) | <input type="checkbox"/> |
| Myocardial infarction | <input type="checkbox"/> | Peripheral arterial disease | <input type="checkbox"/> | Heart failure | <input type="checkbox"/> |

Patient's name and surname

Membership number

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 <input type="checkbox"/> No <input type="checkbox"/>

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

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 for use over conventional therapy require a motivation from a specialist physician or endocrinologist.

Patient's name and surname

Membership number

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
		<input type="text"/>					
		<input type="text"/>					
		<input type="text"/>					
		<input type="text"/>					
		<input type="text"/>					
		<input type="text"/>					

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

Name

Registered practice number

Telephone (W)

Fax

Email

Speciality _____

Doctor's signature _____ Date

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 Personal Medical Savings Account (if applicable to the member's benefit option), subject to Remedi's 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 116 116 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**.