



CHRONIC MEDICATION BENEFIT APPLICATION FORM

A. IMPORTANT INFORMATION

1. One application must be completed per beneficiary applying for chronic medication.
2. Allow **5 working** days for the processing of your application.
3. The original prescription must be given to the provider who dispenses your medication.
4. It is essential that you submit all required information correctly and timeously as incomplete forms will not be processed.
5. Approval of chronic medication is subject to the rules of the Scheme and PROVIDENCE Chronic Protocols
6. You may contact the Pharmacy Benefit Management (PBM) Team at (041) 395 4482 or email pbm@providence.co.za.
7. Send completed forms via fax **086 680 8855**, mail **PO Box 1672, Port Elizabeth, 6000** or e-mail pbm@providence.co.za.

B. MEMBER DETAILS

Scheme		Option	
Membership Number			
Surname	First Names		
Title	Date of Birth	Y Y Y Y M M D D	ID Number
Telephone number (Home)	(Work)		
Fax number (Confidential)	Cellular		
Email address (Confidential)			
Postal Address			Code

C. PATIENT DETAILS (Beneficiary who requires Chronic Medication)

Surname		First Names	
Title	Date of Birth	Y Y Y Y M M D D	ID Number
Telephone number (Home)	(Work)		
Fax number (Confidential)	Cellular		
Email address (Confidential)			
The outcome of this application must be communicated to me via my email address: Yes <input type="checkbox"/> No <input type="checkbox"/> OR fax number Yes <input type="checkbox"/> No <input type="checkbox"/>			

D. PATIENT DECLARATION

- By signing below, I hereby give permission for, acknowledge and/or agree to the following:
- My (or my minor dependant's) doctor may provide clinical information regarding my/minor's condition to the PBM Team;
 - Any information concerning this application will remain confidential at all times;
 - It may be a pre-condition to the approval of the Chronic Medication Benefit that I register and comply with the requirements of a Disease Management Programme and that non-compliance may lead to the withdrawal of this benefit;
 - My (or my minor dependant's) doctor retains the responsibility for my (or my minor dependant's) condition, based on the understanding that I (or my minor dependant) also has a responsibility towards my (or my minor dependant's) own health concerns, irrespective of the outcome of this application.
 - This funding authorisation is at all times subject to the Scheme rules even if a member's circumstances change after the authorisation is provided. This authorisation is not a guarantee of payment.
 - This funding authorisation is based on the most appropriate clinical criteria in terms of the Scheme rules and protocols. All treatment decisions remain the responsibility of the of the beneficiary's health care provider irrespective of the funding decision made in terms of the Scheme rules, clinical criteria and protocols.
 - PROVIDENCE shall not accept responsibility for any act, errors or omissions, loss, damage or consequences of individual responses to the treatment authorised or not authorised for funding by the Scheme.

Patient Signature (or member if patient is a minor) _____ Date

Y	Y	Y	Y	M	M	D	D
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E. PATIENT HEALTH INFORMATION (to be completed by doctor)

Weight		kg	Height		m	Hip/Waist ratio		Smoker?		Ave per day	
Exercise: Frequency	X per week		Intensity (Please tick)	Low	<input type="checkbox"/>	Medium	<input type="checkbox"/>	High	<input type="checkbox"/>		
Current blood pressure	mmHg		Fasting Blood Glucose (If available)	mmol/L							

