

APPLICATION FORM

CHRONIC MEDICINE PROGRAMME

TO BE COMPLETED BY APPLICANT

MEMBER DETAILS:

OPTION

MEMBERSHIP NUMBER

SURNAME

TITLE INITIALS

E-MAIL ADDRESS

PATIENT DETAILS:

NAME AND SURNAME

TITLE ID NUMBER OR DATE OF BIRTH

ADDRESS

E-MAIL ADDRESS

TELEPHONE (H) (W)
 (CELL)

I authorise my medical practitioner to furnish and/or disclose to the Chronic Medicine Programme any fact relating to this application as well as any additional information that may be required from time to time. (Remember that your medical practitioner bears the responsibility of prescribing the medication for you, irrespective of the benefit authorised.)

MEMBER'S SIGNATURE _____ DATE

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

DOCTOR DETAILS:

SURNAME INITIALS

PRACTICE NUMBER SPECIALITY

TELEPHONE FAX

CELLPHONE

POSTAL ADDRESS CODE

E-MAIL ADDRESS

MEDICATION STOPPED (Please use block letters)

| ICD-10 Code(s) | Diagnosis | Name (trade name or generic equivalent) | Strength (e.g. 50mg) | Directions (e.g. 2tds) | Date medication stopped |
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PRESCRIBED MINIMUM BENEFITS

If your patient has one or more of the following chronic conditions, he/she may qualify for additional services. Please indicate which condition(s) he/she has by placing an "X" next to the applicable condition.

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|--------------------------|--|--------------------------|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | Addison's Disease | <input type="checkbox"/> | Crohn's Disease | <input type="checkbox"/> | Hypertension |
| <input type="checkbox"/> | Asthma | <input type="checkbox"/> | Diabetes Insipidus | <input type="checkbox"/> | Hypothyroidism |
| <input type="checkbox"/> | Bipolar Mood Disorder | <input type="checkbox"/> | Diabetes Mellitus Type 1 | <input type="checkbox"/> | Multiple Sclerosis |
| <input type="checkbox"/> | Bronchiectasis | <input type="checkbox"/> | Diabetes Mellitus Type 2 | <input type="checkbox"/> | Parkinson's Disease |
| <input type="checkbox"/> | Cardiac Failure | <input type="checkbox"/> | Dysrhythmias | <input type="checkbox"/> | Rheumatoid Arthritis |
| <input type="checkbox"/> | Cardiomyopathy Disease | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | Schizophrenia |
| <input type="checkbox"/> | Chronic Obstructive Pulmonary Disorder | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | Systemic Lupus Erythematosus |
| <input type="checkbox"/> | Chronic Renal Disease | <input type="checkbox"/> | Haemophilia | <input type="checkbox"/> | Ulcerative Colitis |
| <input type="checkbox"/> | Coronary Artery Disease | <input type="checkbox"/> | Hyperlipidaemia | | |

I hereby acknowledge that the scheme has appointed Qualsa Healthcare (Pty) Ltd as the administrator of the programme and that any prescribed medical treatment shall be the sole responsibility of my medical practitioner.

I understand that the information provided on this form shall be treated as confidential and will not be used or disclosed except for the purpose for which it has been obtained.

Whilst Qualsa undertakes to take all reasonable precautions to uphold the confidentiality of information disclosed to it, I am aware that my medical scheme and practitioner (where necessary) shall also gain access to the same information. I shall therefore not hold Qualsa liable for any claims by me or my dependants arising from any unauthorised disclosure of my personal information to other parties.

I hereby certify that the information provided is true and correct.

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| MEMBER'S SIGNATURE | PRESCRIBING DOCTOR'S SIGNATURE | <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px; text-align: center;">D</td> <td style="width: 20px; height: 20px; text-align: center;">D</td> <td style="width: 20px; height: 20px; text-align: center;">M</td> <td style="width: 20px; height: 20px; text-align: center;">M</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> </tr> </table> DATE | D | D | M | M | Y | Y | Y | Y | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| D | D | M | M | Y | Y | Y | Y | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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PLEASE FAX THE COMPLETED FORM TOLL FREE TO 0800 122 236 OR POST TO THE CHRONIC MEDICINE PROGRAMME,
PO BOX 32921, BRAAMFONTEIN 2017

CONTACT DETAILS: CHRONIC MEDICINE PROGRAMME TEL 0800 122 263 FAX 0800 122 236 E-MAIL transmeddisease@qualsa.co.za
A MEMBER OF METROPOLITAN HEALTH GROUP