Chronic Illness Benefit Application form 2018

Discovery Health Medical Scheme

Contact us

Tel (Members): 0860 99 88 77, Tel (Health partners): 0860 44 55 66, PO Box 784262, Sandton, 2146, www.discovery.co.za.

Who we are

Discovery Health Medical Scheme (referred to as 'the Scheme'), registration number 1125, is the medical scheme. This is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the administrator') is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Discovery Health Medical Scheme and takes care of the administration of your membership.

Purpose of form

This application form is to apply for the Chronic Illness Benefit and is only valid for 2018.

How to complete this form

- Fill in the form in black ink and print clearly, or complete the form digitally by using Microsoft Word.
- All relevant sections must be physically signed and cannot be signed digitally. The patient must sign and date any changes.
- Complete and sign section 1, and fill in your details on the top of page 4, 5, 6 and 7.
- Take the application form to your doctor to complete section 2, other relevant sections, sign section 9 and attach any test results, clinical reports or other information that we need to review the request. These requirements are shown in Sections 3 and 4.
- Fax the completed application form and all supporting documents 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.

1. Patient's details

Title _____ Initials _____ Surname _____

First name(s) (as per identity document) _____

Identity number N N N N N N N N N N N N N Gender ☐ M ☐ F Date of birth Y Y Y Y M M D D

Membership number N N N N N N N N N

Telephone (H) _____ _____ Telephone (W) _____ _____

Cellphone _____ _____ Fax _____ _____

Email _____

The outcome of this application can be communicated to me by ☐ Email ☐ Fax

I acknowledge that I have read and understood the conditions under "Member's acceptance and permission" on page 2.

Patient's signature (if patient is a minor, main member to sign) _____ Date Y Y Y Y M M D D

⚠ **Please only sign if information is true, complete and correct**

2. Doctor's details

Name and surname _____

BHF practice number N N N N N N N N N

Speciality _____

Telephone _____ _____ Fax _____ _____

Email _____

The outcome of this application can be communicated to me by ☐ Email ☐ Fax

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Member's acceptance and permission

I give permission for my healthcare provider to provide Discovery Health Medical Scheme and Discovery Health (Pty) Ltd (as administrator) with my diagnosis and other relevant clinical information required to review my application. I agree to my information being used to develop registries. This means that you give permission for us to collect and record information about your condition and treatment. This data will be analysed, evaluated and used to measure clinical outcomes and make informed funding decisions.

I understand that:

2.1. Funding from the Chronic Illness Benefit is subject to meeting benefit entry criteria requirements as determined by Discovery Health Medical Scheme.
2.2. 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.
2.3. 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.
2.4. Funding for medicine from the Chronic Illness Benefit will only be effective from when Discovery Health Medical Scheme receives an application form that is completed in full. Please refer to the table in Sections 3 and 4 to see what additional information is required to be submitted for the condition for which you are applying.
2.5. Payment to the healthcare professional for the completion of this form, on submission of a claim, is subject to Discovery Health Medical Scheme rules and where the member is a valid and active member at the service date of the claim.

Consent for processing my personal information

I give the Scheme and Administrator consent to have access to and process all information (including general, personal, medical or clinical information) that is relevant to this application. I understand that this information will be used for the purposes of applying for and assessing my funding request for Chronic Illness Benefits. I consent to the Scheme and Administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical information) to my healthcare provider, to administer the Chronic Illness Benefits.

3. The Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions covered on all plans

Discovery Health Medical Scheme covers the following Prescribed Minimum Benefit Chronic Disease List conditions in line with legislation.

Chronic disease list condition	Benefit entry criteria requirements
Addison's disease	Application form must be completed by a paediatrician (in the case of a child), endocrinologist or specialist physician
Asthma	None
Bipolar Mood Disorder	Application form must be completed by a psychiatrist
Bronchiectasis	Application form must be completed by a paediatrician (in the case of a child), pulmonologist or specialist physician
Cardiac failure	None
Cardiomyopathy	None
Chronic obstructive pulmonary disease (COPD)	1. Please attach a lung function test (LFT) report which includes the FEV1/FVC post bronchodilator use 2. Please attach a motivation 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 or specialist physician 2. Please attach a diagnosing laboratory report reflecting creatinine clearance
Coronary artery disease	None
Crohn's disease	Application form must be completed by a paediatrician (in the case of a child), gastroenterologist, specialist physician or surgeon
Diabetes insipidus	Application form must be completed by an endocrinologist
Diabetes Type 1	None
Diabetes Type 2	Section 8 of this application form must be completed by the doctor
Dysrhythmia	None
Epilepsy	Application form for newly diagnosed patients 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 HIVCare programme, please call 0860 100 417
Hyperlipidaemia	Section 6 of this application form must be completed by the doctor
Hypertension	Section 5 of this application form must be completed by the doctor
Hypothyroidism	Section 7 of this application form must be completed by the doctor
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 or specialist physician
Rheumatoid arthritis	Application form must be completed by a rheumatologist, specialist physician, pulmonologist or paediatrician (in the case of a child)
Schizophrenia	Application form must be completed by a psychiatrist
Systemic lupus erythematosus	Application form must be completed by a paediatrician (in the case of a child), rheumatologist, nephrologist, pulmonologist or specialist physician
Ulcerative colitis	Application form must be completed by a paediatrician (in the case of a child), gastroenterologist, specialist physician or surgeon

4. The Additional Disease List (ADL) conditions covered on Executive and Comprehensive Plans

If you are on an Executive or Comprehensive Plan you have cover for all the chronic conditions in the Additional Diseases List below. Your cover is subject to benefit entry criteria.

Additional disease list	Benefit entry criteria requirements
Ankylosing spondylitis	Application form must be completed by a rheumatologist or specialist physician
Behcet's disease	Application form must be completed by a rheumatologist or specialist physician
Cystic fibrosis	Application form must be completed by a pulmonologist, paediatrician (in the case of a child) or specialist physician
Delusional disorder*	Application form must be completed by a psychiatrist
Dermatopolymyositis	Application form must be completed by a dermatologist, rheumatologist or specialist physician
Generalised anxiety disorder*	Applications for first line therapy will be accepted from GPs for 6 months only. Psychiatrist motivation is required for further cover
Huntington's disease	Application form must be completed by a psychiatrist or neurologist
Isolated growth hormone deficiency in children under 18 years	1. Application form must be completed by an endocrinologist or paediatrician. 2. All applications must be accompanied by the relevant laboratory results and growth chart
Major depression*	Applications for first line therapy will be accepted from GPs for 6 months only. Psychiatrist motivation is required for further cover
Motor neurone disease	None
Muscular dystrophy and other inherited myopathies*	None
Myasthenia gravis*	None
Obsessive compulsive disorder	Application form 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 for patients <50 years 3. Please attach information on additional risk factors in patient, where applicable 4. Please indicate if the patient sustained an osteoporotic fracture
Paget's disease	Application form must be completed by a specialist physician or paediatrician (in the case of a child)
Panic disorder	Applications for first line therapy will be accepted from GPs for 6 months only. Psychiatrist motivation is required for further cover
Polyarteritis nodosa	Application form must be completed by a rheumatologist
Post-traumatic stress disorder*	Application form must be completed by a psychiatrist
Psoriatic arthritis	Application form must be completed by a rheumatologist or specialist physician
Pulmonary interstitial fibrosis	Application form must be completed by a pulmonologist, paediatrician (in the case of a child) or specialist physician
Sjogren's syndrome	Application form must be completed by a rheumatologist or specialist physician
Systemic sclerosis	Application form must be completed by a rheumatologist or specialist physician
Wegener's granulomatosis	Application form must be completed by a rheumatologist or specialist physician

* Although these Diagnostic Treatment Pair Prescribed Minimum Benefit (DTP PMB) conditions are covered on all plan types, the PMB cover does not extend to medicine management. They are included on the Additional Disease List to allow funding for medicines for members on the Executive and Comprehensive Plans.

Patient name and surname _____

Membership number | N | N | N | N | N | N | N | N | N |

5. Application for hypertension (to be completed by doctor)

If the patient meets the requirements listed in either A, B or C below, hypertension will be approved for funding from the Chronic Illness Benefit. We may request and review the member's information retrospectively.

A. Previously diagnosed patients

Was the diagnosis made more than six (6) months ago and has the patient been on treatment for at least that period of time? ☐ Yes

B. Please indicate if your patient has any of these conditions

☐ Chronic renal disease ☐ Peripheral arterial disease ☐ Angina ☐ Hypertensive retinopathy ☐ TIA

☐ Stroke ☐ Myocardial infarction ☐ Prior CABG ☐ Pre-eclampsia

C. Newly diagnosed patients

Diagnosis made within the last six (6) months.

Blood pressure ≥ 130/85 mmHg and patient has diabetes or congestive cardiac failure or cardiomyopathy ☐ Yes

OR

Blood pressure ≥ 160/100 mmHg ☐ Yes

OR

Blood pressure ≥ 140/90 mmHg on two or more occasions, despite lifestyle modification for at least 6 months ☐ Yes

OR

Blood pressure ≥ 130/85 mmHg and the patient has target organ damage indicated by ☐ Yes

- Left ventricular hypertrophy or
- Microalbuminuria or
- Elevated creatinine

Patient name and surname _____

Membership number | N | N | N | N | N | N | N | N | N |

6. Application for hyperlipidaemia (to be completed by doctor)

If the patient meets the requirements listed in either A, B, C or E below, hyperlipidaemia will be approved for funding from the Chronic Illness Benefit. Information provided in section D will be reviewed on an individual basis. We may request and review the member's information retrospectively.

A. Primary prevention

Please **attach the diagnosing lipogram**.

Please supply the patient's current blood pressure reading _____ / _____ mmHg

Is the patient a smoker or has the patient ever been a smoker? ☐ Yes ☐ No

Please give details of family history of major cardiovascular events:

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

Please use the Framingham 10-year risk Assessment Chart to determine the absolute 10-year risk of a coronary event (2012 South Africa Dyslipidaemia Guideline)

Does the patient have a risk of 20% or greater ☐ Yes

OR

Is the risk 30% or greater when extrapolated to age 60 ☐ Yes

B. Familial hyperlipidaemia

Please attach the diagnosing lipogram

Was the patient diagnosed with homozygous familial hyperlipidaemia and was the diagnosis confirmed by an endocrinologist or lipidologist? ☐ Yes

Please attach supporting documentation.

OR

Was the patient diagnosed with heterozygous familial hyperlipidaemia and was the diagnosis confirmed by a specialist? ☐ Yes

Please attach supporting documentation and complete the section below.

Please give details of family history of major cardiovascular events:

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

Please detail signs of familial hyperlipidaemia in this patient:

_____

_____

C. Secondary prevention

Please indicate what your patient has:

☐ Diabetes Type 2
☐ Stroke
☐ TIA
☐ Coronary artery disease
☐ Solid organ transplant (Please supply the relevant clinical information in Section D)
☐ Chronic kidney disease (Please supply the diagnosing laboratory report reflecting creatinine clearance)
☐ Peripheral arterial disease (Please supply the Doppler ultrasound or angiogram)
☐ Diabetes Type 1 with microalbuminuria or proteinuria
☐ Any vasculitides where there is associated renal disease (Please supply the diagnosing laboratory report reflecting creatinine clearance)

D. Please supply any other relevant clinical information about this patient that supports the use of a lipid lowering drug:

_____

_____

E. Was the patient diagnosed with hyperlipidaemia more than five years ago and the laboratory results are not available? ☐ Yes

Patient name and surname

Membership number | N | N | N | N | N | N | N | N | N |

7. Application for hypothyroidism (to be completed by doctor)

If the patient meets the requirements listed in either A, B, C, D or E below, hypothyroidism will be approved for funding from the Chronic Illness Benefit. We may request and review the member's information retrospectively.

A. Thyroidectomy Please indicate whether your patient has had a thyroidectomy ☐ Yes

B. Radioactive iodine Please indicate whether your patient has been treated with radioactive iodine ☐ Yes

C. Hashimoto's thyroiditis Please indicate whether your patient has been diagnosed with Hashimoto's thyroiditis ☐ Yes

D. Please attach the initial or diagnostic laboratory results that confirm the diagnosis of hypothyroidism, including TSH and T4 levels

Was the diagnosis based on the presence of **clinical symptoms and one of the following:**

A raised TSH and reduced T4 level ☐ Yes

OR

A raised TSH but normal T4 and higher than normal thyroid antibodies ☐ Yes

OR

A raised TSH level of greater than or equal to 10 on two or more occasions at least three months apart in a patient with normal T4 ☐ Yes

E. Was the patient diagnosed with hypothyroidism more than five years ago and the laboratory results are not available? ☐ Yes

8. Application for diabetes type 2 (to be completed by doctor)

If the patient meets the requirements listed in either A, B or C below, diabetes type 2 will be approved for funding from the Chronic Illness Benefit. We may request and review the member's information retrospectively.

A. Please attach the initial or diagnostic laboratory results that confirm the diagnosis of diabetes type 2
Please note that finger prick and point of care tests are not accepted for registration on the Chronic Illness Benefit.

Do these results show:
A fasting plasma glucose concentration ≥ 7.0 mmol/l ☐ Yes

OR

A random plasma glucose ≥ 11.1 mmol/l ☐ Yes

OR

A two-hour post-glucose ≥ 11.1 mmol/l during an oral glucose tolerance test (OGTT) ☐ Yes

OR

An HbA1C ≥ 6.5% ☐ Yes

B. Is the patient a type 2 diabetic on insulin ☐ Yes

C. Was the patient diagnosed with diabetes type 2 more than five years ago and the laboratory results are not available? ☐ Yes
Important: please note that no exceptions will be made for patients being treated with Metformin monotherapy.

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Patient name and surname _____

Membership number | N | N | N | N | N | N | N | N | N |

9. Medicine required (to be completed by doctor)

Formulary medicine will be funded up to the Discovery Health Rate. There will be no co-payment for medicine selected from the formulary.

For non-formulary medicine, we fund up to the Chronic Drug Amount (CDA), which is a monthly amount we pay up to, for a specific medicine class. The member may be liable for a co-payment where the cost of the medicine is greater than the CDA (not applicable for Smart and KeyCare plans).

ICD-10	Diagnosis description	Date when condition was first diagnosed	Medicine name, strength and dosage	How long has the patient used this medicine?	
				Years	Months

Notes to doctors

9.1. 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 subject to Discovery Heath Medical Scheme rules and where the member is a valid and active member at the service date of the claim.

9.2. 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 funding for multiple chronic conditions were applied for, then it would be appropriate to list all the relevant ICD-10 codes.

9.3. We will approve funding for generic medicine, where available, unless you have indicated otherwise.

9.4. Please submit all the requested supporting documents with this application to prevent delays in the review process.

9.5. You may call 0860 44 55 66 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.**

Doctor's signature _____ Date | Y | Y | Y | Y | M | M | D | D |

⚠ **Please only sign if information is true, complete and correct.**