Chronic Illness Benefit application form 2013

This application form is to apply for the Chronic Illness Benefit and is only valid for 2013

Discovery Health Medical Scheme

Contact us

Tel: 0860 99 88 77, PO Box 784262, Sandton, 2146, www.discovery.co.za

The latest version of the application form is available on www.discovery.co.za. Alternatively members can phone 0860 99 88 77 and health professionals can phone 0860 44 55 66.

What you must do

Please go through these steps:

Step 1: Fill in and sign the application form (section 1), and fill in your details on the top of page 4, 5, 6, 7 and 8.

Step 2: Take the application form to your doctor to complete and sign Section 2 and other relevant information/sections.

Step 3: 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.

The Scheme has the right to change the rules for membership from time to time. You may ask us for a copy of them 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 or your financial adviser know. Once we have assessed your application, we will let you know.

1. Patient's details

Name and surname

DOB/ID number

Membership number

Telephone Fax

Cellphone

Email

Outcome of this application must be sent to me by Email ☐ Fax ☐

Date Y Y Y Y M M D D

Patient's signature (if patient is a minor, main member to sign)

I acknowledge that I have read and understood the conditions under "Notes to Member" on page 2.

2. Doctor's details

Name and surname

BHF practice number

Speciality

Telephone Fax

Email

Outcome of this application must be sent to me by Email ☐ Fax ☐

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Notes to member

I give permission for my healthcare provider 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 meeting benefit entry requirements as determined by Discovery Health.
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.
4. Funding for medicine from the Chronic Illness Benefit will only be effective from when Discovery Health receives an application form that is completed in full.
5. I may need to send an updated or new application form, if the Chronic Illness Benefit department asks for this.

I consent to Discovery Health disclosing, from time to time, information supplied to Discovery Health (including general or medical information that is relevant to my application) to my healthcare provider, to administer my Chronic Illness Benefit. I agree that Discovery Health may disclose this information at its discretion, but only as long as all the parties involved have agreed to keep the information always confidential.

3. The Prescribed Minimum Benefits (PMB) (for members on Executive, Comprehensive, Priority, Saver, Core and KeyCare Plans)

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

PMB 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	Please attach a lung function test (LFT) report which includes the FEV1 post bronchodilator use for patients who are diagnosed at >50 years of age
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 and FEV1 post bronchodilator use 2. Please attach a motivation from a specialist 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	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 or specialist physician
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
Dysrhythmias	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 must be completed by the doctor
Hypertension	Section 5 must be completed by the doctor
Hypothyroidism	Section 7 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 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 rheumatologist, nephrologist or specialist physician
Ulcerative colitis	Application form must be completed by a gastroenterologist or specialist physician

4. The Additional Disease List (ADL) conditions covered on Executive and Comprehensive Plans (not covered by the Prescribed Minimum Benefits)

If you have 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 rheumatologist or specialist physician
Generalised anxiety disorder	Applications for 1st 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
Major depression	Applications for 1st 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
Overlap syndrome (mixed connective tissue disease)	Application form must be completed by a rheumatologist or specialist physician
Paget's disease	Application form must be completed by a specialist physician or paediatrician (in the case of a child)
Panic disorder	Applications for 1st 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

*This application form is not applicable for applications for biologics (Revellex®, Enbrel®, Humira®, Mabthera®, Orencia®)
Please note that biologics are only covered on Executive and Comprehensive Plans.

Patient's name and surname

Membership number

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.

Please note: *For patients with refractory hypertension who require more than three classes of medicines, the application should be completed by a specialist physician, cardiologist, paediatrician, nephrologist or endocrinologist.*

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 condition(s)

Chronic renal disease	☐	TIA	☐
Hypertensive retinopathy	☐	Angina	☐
Prior CABG	☐	Myocardial infarction	☐
Peripheral arterial disease	☐	Pre-eclampsia	☐
Stroke	☐		

C. Newly diagnosed patients

Diagnosis made within the last six (6) months.

Please note: *Specialist physician, cardiologist, paediatrician, nephrologist or endocrinologist application is required if the patient is younger than 30 years old, as recommended in the "SA Hypertension Guidelines".*

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's name and surname

Membership number

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

If the patient meets the requirements listed in either A, B or C 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**, and confirm that the following secondary causes have been excluded and supply the results:

Hypothyroidism	TSH:	
Diabetes Type 2	Fasting glucose:	
Alcohol excess (where applicable)	gamma-GT:	
Drug-induced hyperlipidaemia	Yes ☐	No ☐

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

Is the patient a smoker (defined as any cigarette smoking in the last month or a history of 20 cigarettes a day for 10 years) 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 (NIH publication no. 01-3670; May 2001)

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

Patient has had diagnosis of homozygous familial hyperlipidaemia confirmed by an endocrinologist or lipidologist. Please attach supporting documentation. Yes ☐

OR

Patient has had diagnosis of heterozygous familial hyperlipidaemia confirmed by a specialist. Please attach supporting documentation and complete the section below. Yes ☐

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 condition(s) your patient has:

Diabetes Type 2	☐	Ischaemic heart disease	☐
Intermittent claudication	☐	Nephrotic syndrome and chronic renal failure	☐
Prior CABG	☐	Diabetes Type 1 with microalbuminuria	☐
Stroke	☐	Any vasculitides where there is associated renal disease	☐
TIA	☐		

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

_____

_____

Patient's name and surname

Membership number

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

If the patient meets the requirements listed in either A, B or C 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. Hashimoto's thyroiditis *Please indicate whether your patient has been diagnosed with Hashimoto's thyroiditis* Yes ☐

C. 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 and clinical symptoms Yes ☐

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

If the patient meets the requirements listed in either A or B 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 $\geq$ 7.0 mmol/l Yes ☐

OR

A random plasma glucose $\geq$ 11.1 mmol/l Yes ☐

OR

Was the two hour post-glucose $\geq$ 11.1 mmol/l during an oral glucose tolerance test (OGTT) Yes ☐

OR

An HbA1C (NGSP certified and standardised to DCCT assay) ≥ 6.5% for your patient where you have excluded other factors which influence HbA1C measurements. Yes ☐

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

Patient's name and surname

Membership number

Medicine required (to be completed by doctor)

Formulary medicine will be funded to the Discovery Health Medicine 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 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

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 from the day-to-day benefits (if applicable to the member's plan type), subject to Scheme rules and availability of funds and where the member is a valid and active member at the service date of the claim.
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 conditons were applied for, then it would be appropriate to list all the relevant ICD-10 codes.
3. We will approve funding for generic medicine, where available, unless you have indicated otherwise.
4. Please submit all the requested supporting documents with this application to prevent delays in the review process.
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**.
6. If you have a complex clinical issue that you need to discuss with a doctor or pharmacist, please call 0860 400 600 or email CIB_APP_FORMS@discovery.co.za

Doctor's signature

Date Y Y Y Y M M D D

Patient's name and surname

Membership number

Exception requests

Please complete the table below where non-formulary medicine is prescribed for the treatment of PMB CDL conditions and the request is for cover without co-payment. Please supply a clinical motivation and supporting documentation where appropriate, as to why the formulary medicine cannot be used by the patient, including details of treatment failure or adverse drug reactions where applicable.

Details of medicine to be funded without co-payment

Medicine name and strength	Quantity	Is the patient controlled? (Please attach relevant details)

Previous medicine history

Medicine name	Date medicine started	Length of therapy	Details of treatment failure or adverse effects

Doctor's signature

Date Y Y Y Y M M D D