Chronic Illness Benefit application form 2017

Discovery
Health Medical Scheme

Broker House Name: Aon South Africa (Pty) Ltd
Broker House Code: 1004785125
Broker Code: 1020031108

Contact us

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

Who we are

The 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 and administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider.

This application form is to apply for the Chronic Illness Benefit and is only valid for 2017.

How to complete this form

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

Step 2: Take the application form to your doctor to complete section 2, other relevant sections and sign section 9. Any additional information requested in these sections should be sent with this form.

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.

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 _____

Date of birth/ID number _____

Membership number _____

Telephone _____ _____ Fax _____

Cellphone _____ _____

Email _____

Outcome of this application must be sent 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

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

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 and Discovery Health (Pty) Ltd.

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.

2.5. I may need to send an updated or new application form, if the Chronic Illness Benefit department asks for this.

2.6. Payment 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.

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

3. The Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions covered on Executive, Comprehensive, Priority, Saver, Smart, Core and KeyCare Plans

For information only.

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 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	None
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 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 rheumatologist, nephrologist, pulmonologist 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

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 condition	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 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'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.

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	☐	Stroke	☐	Myocardial infarction	☐
Prior CABG	☐	TIA	☐	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'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, 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**, 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 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 (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

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 conditions your patient has:

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

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'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, 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.

Patient's name and surname _____

Membership number _____

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

Discovery Health Medical Scheme is a registered medical scheme and regulated by the Council for Medical Schemes (CMS). The CMS contact details are as follows: Email: complaints@medicalschemes.com | Customer Care Centre: 0861 123 267 | website: www.medicalschemes.com

Empower Results®

Contact us on: **0860 tel arc / 0860 835 272,** P.O. Box 1874, Parklands, 2121, www.aon.co.za
FSB number: 20555; CMS number: ORG895

Acknowledgement of appointment

I hereby authorise Aon South Africa (Pty) Ltd to be my duly appointed Broker with immediate effect.

My ID ☐☐☐☐☐☐☐☐☐☐☐☐☐ and membership number ☐☐☐☐☐☐☐☐☐☐☐☐☐

I have also been informed of the commission due to Aon, payable by the medical scheme as part of my monthly contribution, is 3% of the contribution to a maximum of R85.00 excl. Vat per month. I have further been issued with a Statutory Notice and Section 13 certificate.

Signed at (town or city) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ on yy/mm/dd ☐☐☐☐☐☐

Signature ☐

Permission to make certain information available to Aon South Africa (Pty) Ltd

I give consent for the disclosure of information about me.

Membership number ☐☐☐☐☐☐☐☐☐☐☐☐☐

Medical Scheme ☐ Aon Broker Code ☐

Title ☐☐☐☐ Initials ☐☐☐☐ Surname ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐