transmed
MEDICAL FUND

APPLICATION FORM
CHRONIC MEDICINE PROGRAMME

TO BE COMPLETED BY APPLICANT

MEMBER DETAILS:

Plan

Membership number

Surname

Title Initials

Email address

PATIENT DETAILS:

Name and surname

Title ID number or date of birth

Address

Email address

Telephone (H) (W)

(Cell phone)

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 D D M M Y Y Y Y

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

DOCTOR DETAILS:

Surname Initials

Speciality

Practice number Telephone

Fax Cell phone

Postal address

Code

Email address

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER (CONTINUED)

ASSOCIATED SPECIALIST DETAILS:

Name

Practice number Speciality

CLINICAL EXAMINATION:

Gender ☐ M ☐ F Weight ☐☐☐ kg Height ☐☐☐ cm Blood pressure ☐☐☐/☐☐☐

Smoking	☐ Never	☐ Ex-smoker	☐ <10 per day	☐ <10 per day
Exercise	☐ Never	☐ <1 hour per week	☐ 1-3 hours per week	☐ >3 hours per week
Allergies	☐ Penicillin	☐ Aspirin	☐ Sulphonamides	

Other

The Chronic Medicine Programme requires certain special investigations to expedite the chronic authorisation process. This includes, but is not limited to, the following:

» Angiotensin receptor blockers (ARBs):	Motivation
» Bisphosphates and other agents for osteoporosis:	Bone mineral density and motivation
» Chronic obstructive airways disease:	Lung function tests
» Chronic renal failure:	Creatinine clearance/glomerular filtration rate
» Haemophilia:	Factors VIII and IX blood levels
» Hyperlipidaemia:	Lipogram*
» Long-acting insulin analogues, glitazones:	HbA_{1c} and motivation

* In primary prevention patients requesting lipid-modifying therapy (e.g. statins), reimbursement is reserved for patients with a greater than 20% risk of an acute clinical coronary event within the next 10 years, as calculated by the Framingham Risk Calculation and in accordance with locally and internationally accepted treatment guidelines.

Please indicate below where you agree to a generic substitution and provide your preferred medication name. Chronic medicine is subject to generic reference pricing.

MEDICATION PRESCRIBED (PLEASE USE BLOCK LETTERS)

ICD-10 code/s	Detailed diagnosis and date of diagnosis	Name (trade name or generic equivalent)	Generic substitution		Strength (e.g. 50mg)	Directions (e.g. 2tds)	Date medication started	Type and date of investigation/report
			Yes	No				

Membership no. Doctor's practice no.

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

PRESCRIBED MINIMUM BENEFITS

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

	Addison's disease		Crohn's disease		Hypertension
	Asthma		Diabetes insipidus		Hypothyroidism
	Bipolar mood disorder		Diabetes mellitus type 1		Multiple sclerosis
	Bronchiectasis		Diabetes mellitus type 2		Parkinson's disease
	Cardiac failure		Dysrhythmias		Rheumatoid arthritis
	Cardiomyopathy disease		Epilepsy		Schizophrenia
	Chronic obstructive pulmonary disorder		Glaucoma		Systemic lupus erythematosus
	Chronic renal disease		Haemophilia		Ulcerative colitis
	Coronary artery disease		Hyperlipidaemia		

CONSENT

I hereby acknowledge that the Fund has appointed Momentum Health Solutions (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.

I hereby give my consent to Momentum Health Solutions and its staff to obtain my special personal information (i.e. health and biometric) from my healthcare providers (pharmacy, pathology, medical doctor and radiology) to assess my medical risk and enrol me on the programme and to use such information to my benefit. I understand and agree that special personal information relevant to my current state of health can be disclosed to third parties for the purpose of scientific, epidemiological and/or financial analysis without disclosure of my identity.

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

Continued overleaf »

Membership no. | | | | | | | | | | | | | |

Doctor's practice no. | | | | | | | | | | | | | |

CONSENT

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

Member's signature	Prescribing doctor's signature	Date (D D M M Y Y Y Y)

Membership no. | | | | | | | | | | | | |

Doctor's practice no. | | | | | | | | | | | | |

11/19