transmed
MEDICAL FUND

APPLICATION FORM
PMB TREATMENT PLAN

Please complete this application if your patient has been diagnosed with a PMB chronic condition and is not on chronic medication. However, should your patient require authorisation of medication, kindly complete a medicine risk management application form.

TO BE COMPLETED BY APPLICANT

MEMBER DETAILS:

Membership number | ID number

Surname

Title | Initials

Email address

Telephone (H) (W)

(Cell phone)

DEPENDANT DETAILS:

Name and surname

Title | ID number or date of birth

Address

Code

Email address

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

DOCTOR DETAILS:

Surname | Initials

Practice number

Speciality

Telephone | Fax

Cell phone

Postal address

Code

Email address

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER (CONTINUED)

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 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Please note that clinical information is mandated prior to the authorisation of a PMB care plan and when additional services are required.

PRESCRIBED MINIMUM BENEFITS

Please indicate which condition(s) your patient 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 I		Multiple sclerosis
	Bronchiectasis		Diabetes mellitus type II		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		

Please take note of the following:

» The information contained in this application form is used to draw up your PMB care plan.
» Treatment and care is strictly for the 26 PMB chronic disease list (CDL) conditions. Please ensure that your treating doctor includes the correct ICD-10 codes to ensure that your claims are paid from the appropriate benefit.
» If you or your beneficiary is authorised for a PMB care plan during the course of the year, the services outlined in the care plan will be granted on a prorated basis.

PATIENT CONSENT

1. I hereby confirm that the information provided in this application is true and correct.
2. I acknowledge that Momentum Health Solutions (Pty) Ltd is the administrator of the programme and that any medical treatment prescribed as well as the general management of my chronic condition(s) will be the sole responsibility of my medical practitioners, in consultation with me. Momentum Health Solutions and the Fund and/or employer will accordingly not be held liable for any claims by me or my dependants arising from the implementation of the programme.
3. I hereby give my consent to Momentum Health Solutions, including their agents and medical 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.
4. I understand that no information regarding my case will be made available to my employer/s or any other person not directly involved in my care.
5. I give my consent to Momentum Health Solutions to electronically store, access, process and retain my special personal information for the purposes set out in this document as may otherwise be required to administer the programme.
6. 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/or employer 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. ☐☐☐☐☐☐☐☐☐☐☐☐☐

PATIENT CONSENT (CONTINUED)

7. I shall be entitled to terminate my participation in the programme at any time with immediate effect on notice to the Fund, but understand that all benefits that I enjoyed under the programme shall immediately cease and the Fund shall not be obliged to reinstate such benefits at any time thereafter. I understand that the consequences of such a decision will rest with me alone.
8. I acknowledge that, should I not comply with the programme protocols or prescribed treatment, the Fund and/or employer at its sole discretion may elect to exercise its rights and limit my benefits to the prescribed minimum benefits (PMBs), subject to the applicable legislation and the Fund rules.
9. I understand that telephone calls will be recorded for internal clinical quality assurance purposes and will not be shared outside of the programme.
10. I understand and acknowledge that 'consent', for the purposes of this document, means my informed consent, in other words:
    - 10.1 I have read and understood the contents of this document.
    - 10.2 I understand and acknowledge the nature and purpose for which the personal medical information that will be made available to and disclosed, used, processed and retained by the Fund and my healthcare providers, as set out in this consent.
    - 10.3 I have the legal capacity to give my informed consent, in other words, I am over the age of 18 and am able to fully understand and make decisions about my healthcare.

_____

Patient's signature
(or signature of parent/guardian if patient is under the age of 18 years)

D	D	M	M	Y	Y	Y	Y

Date

_____

Doctor's signature

D	D	M	M	Y	Y	Y	Y

Date

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

06/2021

INTEGRATED CARE PROGRAMME, PO BOX 2269, BELLVILLE 7535

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