APPLICATION FORM
INTEGRATED CARE PROGRAMME

PLEASE USE BLOCK LETTERS FOR ALL SECTIONS

1. MEMBER AND PATIENT INFORMATION

TO BE COMPLETED BY THE APPLICANT

MAIN MEMBER DETAILS

Membership number

Benefit option ☐ Select Plan ☐ Prime Plan ☐ Guardian Plan

Title | Initials | ID number

Full name and surname

Email address

PATIENT DETAILS

Dependant code

Title | Initials | ID number

Full name and surname

Contact numbers | Home | Work

Cell phone

Kindly indicate your preferred day and time for contact (Mon - Fri 9:00 - 16:00)

Postal address

Postal code

Email address

PATIENT CONSENT

I understand that Transmed Medical Fund (Transmed) and Momentum Health Solutions, the Administrator, will maintain the confidentiality of my personal information and comply with the Protection of Personal Information Act 4 of 2013 (POPIA) and all existing data protection legislation, when collecting, processing and storing my personal information for the purposes of registration on the Integrated Care Programme.

I understand that:

- Funding for this benefit is subject to meeting benefit entry criteria requirements as determined by the Fund.
- The benefit provides cover for therapy scientifically proven for my condition, which means that not all medication for the condition will automatically be covered.
- By registering for the 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.
- Funding will only be effective once the Fund receives an application form that is completed in full.
- Payment to the healthcare professional for the completion of this form, on submission of a claim, will be subject to the Fund rules and where the member is a valid and active member at the service date of the claim.
- 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 to make informed funding decisions.

Membership number | **Doctor's practice number**

1. MEMBER AND PATIENT INFORMATION (CONTINUED)

TO BE COMPLETED BY THE APPLICANT (CONTINUED)

PATIENT CONSENT (CONTINUED)

- To ensure that we pay your claims from the correct benefit, any claims from your healthcare providers must include the relevant ICD-10 diagnosis code(s). Please ask your doctor to also include the relevant ICD-10 diagnosis code(s) on the referral form for any pathology and/or radiology tests. This will enable the pathologists and radiologists to also include the relevant ICD-10 diagnosis code(s) on the claims they submit, thus further ensuring that we pay your claims from the correct benefit.

CONSENT FOR PROCESSING MY PERSONAL INFORMATION

1. I hereby acknowledge that Transmed 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.
2. I hereby give my consent to the Fund, Momentum Health Solutions and its employees to obtain my, or any of my dependants', special personal information (including general, personal, medical or clinical), whether it relates to the past or future (e.g. health and biometric) from any of my healthcare providers (e.g. pharmacist, pathologist, radiologist, treating doctor and/or specialist) to assess my medical risk, enrol me on the programme and to use such information to my benefit and to undertake managed care interventions related to my chronic condition(s).
3. I understand that this information will be used for the purposes of applying for and assessing my funding request for chronic benefits.
4. I give permission for my healthcare provider to provide the Fund and the administrator with my diagnosis and other relevant clinical information required to review and process my application.
5. I consent to the Fund and the administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical) to my healthcare provider, to administer the chronic benefits.
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 my healthcare provider (where necessary) shall also gain access to the same information. I shall therefore not hold Momentum Health Solutions and its employees or the Fund and its trustees, liable for any claims by me or my dependants arising from any unauthorised disclosure of my special personal information to other parties.
7. I understand and agree that special personal information relevant to my current state of health may be disclosed to third parties for the purpose of scientific, epidemiological and/or financial analysis without disclosure of my identity.

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

Member/patient signature
(or signature of parent/ guardian if patient is under the age of 18)

Date
DD/MM/YYYY

2. MEDICAL PRACTITIONERS' INFORMATION

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

DOCTOR DETAILS

Practice number

Initials

Speciality

Surname

Contact numbers

Work

Fax

Cell phone

Postal address

Postal code

Email address

Membership number

Doctor's practice number

2. MEDICAL PRACTITIONERS' INFORMATION (CONTINUED)

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER (CONTINUED)

ASSOCIATED SPECIALIST DETAILS

Practice number | Speciality

Full name and surname

Contact number

Email address

3. CLINICAL EXAMINATION

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

Gender ☐ Male ☐ Female ☐ Other | Weight ☐ kg | Height ☐ cm

Smoker ☐ 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

DETAILS OF DIAGNOSIS

Diagnosis	ICD-10 code(s)	Description	Date of diagnosis (DD/MM/YYYY)
Primary:			
Other:			

BLOOD GLUCOSE RESULTS

HbA_{1c}

Reading 1 ☐ % Test date ☐ (DD/MM/YYYY)

Reading 2 ☐ % Test date ☐

Reading 3 ☐ % Test date ☐

Blood glucose

Reading 1 ☐ mmol/L Test date ☐ (DD/MM/YYYY)

Reading 2 ☐ mmol/L Test date ☐

Reading 3 ☐ mmol/L Test date ☐

Membership number ☐ **Doctor's practice number** ☐

3. CLINICAL EXAMINATION (CONTINUED)

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER (CONTINUED)

CARDIAC RESULTS

Blood pressure	Reading 1		/		mmHg	Test date (DD/MM/YYYY)
	Reading 2		/		mmHg	Test date
	Reading 3		/		mmHg	Test date

RESPIRATORY RESULTS

Forced expiratory volume (FEV1%)	Reading 1	%	Test date	(DD/MM/YYYY)
	Reading 2	%	Test date	
	Reading 3	%	Test date	
Peak flow	Reading 1	%	Test date	(DD/MM/YYYY)
	Reading 2	%	Test date	
	Reading 3	%	Test date	

LIPOGRAM RESULTS

Total cholesterol	Reading 1	mmol/L	Test date	(DD/MM/YYYY)
	Reading 2	mmol/L	Test date	
	Reading 3	mmol/L	Test date	
Low-density lipoproteins (LDL)	Reading 1	mmol/L	Test date	(DD/MM/YYYY)
	Reading 2	mmol/L	Test date	
	Reading 3	mmol/L	Test date	
Triglycerides (TG)	Reading 1	mmol/L	Test date	(DD/MM/YYYY)
	Reading 2	mmol/L	Test date	
	Reading 3	mmol/L	Test date	

PRESCRIBED MINIMUM BENEFITS

If your patient has one of more of the following chronic conditions, they may qualify for additional services. Please indicate which condition(s) your patient have.

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

If your patient is at risk of being HIV positive, or has been diagnosed as a person living with HIV/AIDS, please advise them to register on the HIV **YourLife** Programme on 0860 109 793 (all calls are confidential).

Membership number _____ **Doctor's practice number** _____

3. CLINICAL EXAMINATION (CONTINUED)

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER (CONTINUED)

Additional information relevant to your patient's condition(s):

4. CHRONIC MEDICATION APPLICATION

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

Please complete this application for chronic medication, if applicable to the patient.

Please note: Prescribed Minimum Benefit rules, chronic disease lists and medication formularies applicable to your benefit option will apply. As per the requirements of the Government Risk Equalisation Fund (REF), in order to register patients on the Chronic Medicine Risk Management Programme, documentation from a relevant specialist and/or test results verifying the diagnosis, is required for, but is not limited to, the following:

- Chronic obstructive airways disease: Documentation of lung function tests (most recent)
- Chronic renal failure: Documentation of creatinine clearance or Glomerular Filtration Rate (GFR) estimate (most recent)
- Haemophilia: Factors VIII and IX blood levels
- Hyperlipidaemia: Pre-treatment lipogram
- Diabetes type 1 or 2 and/or second- or third-line drugs: HbA1c and motivation

MEDICATION PRESCRIBED

ICD-10 code(s)	**Detailed diagnosis**	**Date of diagnosis** (DD/MM/YYYY)	**Medication name** (trade name or generic equivalent)	**Strength** (e.g. 50mg)	**Directions** (e.g. 2tds)	**Date medication started** (DD/MM/YYYY)

Membership number _____ **Doctor's practice number** _____

4. CHRONIC MEDICATION APPLICATION (CONTINUED)

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER (CONTINUED)

Additional information/motivation:

MEDICATION STOPPED

ICD-10 code(s)	Diagnosis	Medication name (trade name or generic equivalent)	Strength (e.g. 50mg)	Directions (e.g. 2tds)	Date medication stopped (DD/MM/YYYY)

Membership number **Doctor's practice number**