

# APPLICATION FORM

## ACUTE DIALYSIS REQUEST AND UPDATE

Please return the signed and completed form, pathology report(s) and any accompanying documentation by email to [renalcare@transmed.co.za](mailto:renalcare@transmed.co.za).

**PLEASE USE BLOCK LETTERS FOR ALL SECTIONS**

### 1. MEMBER AND PATIENT INFORMATION

#### MAIN MEMBER DETAILS

|                       |  |          |  |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|-----------------------|--|----------|--|----------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Membership number     |  |          |  | Benefit option |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 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 |  |  |  |      |  |  |  |  |  |  |  |             |  |  |  |
| Postal address        |  |          |  |            |  |  |  |      |  |  |  |  |  |  |  |             |  |  |  |
|                       |  |          |  |            |  |  |  |      |  |  |  |  |  |  |  | Postal code |  |  |  |
| Email address         |  |          |  |            |  |  |  |      |  |  |  |  |  |  |  |             |  |  |  |

### 2. PATIENT CONSENT

I understand that Transmed Medical Fund and Momentum Health, 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 Renal Care Management 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.
- 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.

Membership number

Doctor's practice number

## 2. PATIENT CONSENT (CONTINUED)

### Consent for processing my personal information

1. I hereby acknowledge that Transmed Medical Fund has appointed Momentum Health (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 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/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 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 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

## 3. MEDICAL PRACTITIONERS' INFORMATION

### DIALYSIS FACILITY

Practice number

Contact number

Email address

### TREATING NEPHROLOGIST

Full name and surname

Practice number

Contact number

Email address

### Approved authorisation to be sent to:

Full name and surname

Designation

Contact number

Email address

Membership number

Doctor's practice number

#### 4. CLINICAL INFORMATION

|                          |   |                                 |                                |                                |                                |   |
|--------------------------|---|---------------------------------|--------------------------------|--------------------------------|--------------------------------|---|
| ICD-10 code(s)           | <input type="checkbox"/> N17.9          | <input type="checkbox"/> N18.9  |                                |                                |                                |   |
| Type of dialysis         | <input type="checkbox"/> AHD            | <input type="checkbox"/> CVVHD  | <input type="checkbox"/> CRRT  | <input type="checkbox"/> SLED  |                                |   |
| Tariff code for dialysis | <input type="checkbox"/> 75145          | <input type="checkbox"/> 75150  | <input type="checkbox"/> 75151 | <input type="checkbox"/> 75152 | <input type="checkbox"/> 75154 | <input type="checkbox"/> 75156 <input type="checkbox"/> 75999 |
| Type of authorisation    | <input type="checkbox"/> New            | <input type="checkbox"/> Update |                                |                                |                                |   |
| Date treatment started   | <input type="text" value="DD/MM/YYYY"/> |                                 |                                |                                |                                |   |

#### Latest U&E results

Please attach latest U&E results that lead to AHD

Date blood collected

|            |   |
|------------|---|
| Urea       | <input type="text" value="DD/MM/YYYY"/> |
| Creatinine | <input type="text" value="DD/MM/YYYY"/> |
| Potassium  | <input type="text" value="DD/MM/YYYY"/> |
| eGFR       | <input type="text" value="DD/MM/YYYY"/> |

| Type of dialysate | NAPPI code(s) | Quantity |
|-------------------|---------------|----------|
| Duosol            |               |          |
| Accusol           |               |          |
| Other             |               |          |
| 1.                |               |          |
| 2.                |               |          |
| 3.                |               |          |

Additional information:

Membership number

Doctor's practice number

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11/2024

### RENAL CARE MANAGEMENT PROGRAMME

Telephone 0800 225 151 Email [renalcare@transmed.co.za](mailto:renalcare@transmed.co.za) Website [www.transmed.co.za](http://www.transmed.co.za)