transmed MEDICAL FUND

Administered by momentum health

Application form

Out-of-hospital treatment of a prescribed minimum benefit (PMB) condition

IMPORTANT INFORMATION TO NOTE BEFORE COMPLETING THIS FORM

Transmed Medical Fund approves funding for benefits based on treatment protocols for PMB conditions, following guidelines from healthcare authorities and best clinical practices. Full funding may not be provided due to various factors. **This benefit is not applicable for Link Plan members.** Changes to an approved treatment plan will need a new application. Healthcare providers must include correct ICD-10 codes in claims.

How to apply for a prescribed minimum benefit (PMB)

- This form is to be completed by you, as the member, and your treating doctor. Please read each section carefully to make sure that you comply with all the requirements.
- Your member and benefits guide contain details of the chronic conditions and benefits that are covered and guidelines on how to access these benefits.
- The 26 chronic disease list (CDL) conditions, which form part of the prescribed minimum benefits, are listed on pages 6 and 7 of this application form, including details of additional information and tests required per condition.
- If your condition is not one of the 26 CDL conditions as listed below, you or your treating doctor may view the full list of PMB conditions on the Council for Medical Schemes (CMS) website at https://www.medicalschemes.co.za/resources/pmb/pmb-conditions/.
- Your treating doctor will assess you and may prescribe medication as per the Transmed Medical Fund medication formulary. To view the specific medication covered and check for any co-payments, visit https://secure.mediscor.co.za/adocs/scheme formularies/Transmed_Formulary_Lookup.html. If the medication is not on the formulary, please discuss with your treating doctor if you would like to consider changing your medication. It is crucial to always follow your doctor's guidance when it comes to your medication and treatment for your condition.
- The treatment that your doctor prescribes for your condition may also include consultations, pathology tests and/or radiology services.
- Before completing this form, please discuss your treatment plan with your doctor.
- Please return the completed and signed form, including any relevant information and supporting documents to help us in processing your application, by email to disease@transmed.co.za.
- We will review the application and, if approved, we will authorise benefits according to the Fund rules and clinical policies and inform you of our decision.
- If we authorise the medication prescribed by your doctor, you will need to obtain it from your network pharmacy.

PLEASE USE BLOCK LETTERS FOR ALL SECTIONS

Application for: ☐ New ☐ Renewal ☐ Change

1. MEMBER AND PATIENT INFORMATION

TO BE COMPLETED BY THE APPLICANT

Main member details

Membership number

Benefit option ☐ Select Plan ☐ Prime Plan ☐ Guardian Plan **Benefit not applicable for Link Plan members**

Full name and surname

ID number

Race* ☐ African/Black ☐ Coloured/Mixed race ☐ Indian/Asian ☐ White/Caucasian ☐ Other (please specify): _____ ☐ I do not wish to disclose my race

Contact number Alternative contact number

Email address

* Optional information required by the Council for Medical Schemes (CMS) for statistical purposes.

1. MEMBER AND PATIENT INFORMATION (CONTINUED)

TO BE COMPLETED BY THE APPLICANT (CONTINUED)

Patient details

Dependant code

Title | Initials | ID number

Full name and surname

Race*

☐ African/Black ☐ Coloured/Mixed race ☐ Indian/Asian ☐ White/Caucasian

☐ Other (please specify): _____ ☐ I do not wish to disclose my race

Contact number | Alternative contact number

Physical address

Postal code

Email address

*Optional information required by the Council for Medical Schemes (CMS) for statistical purposes.

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 obtaining out-of-hospital treatment for PMB conditions. Accordingly, all medical schemes are legally required to communicate directly with dependants who are 18 years and older.

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.

Consent for processing my personal information

1. I hereby acknowledge that Transmed Medical Fund has appointed Momentum Health (Pty) Ltd as the administrator of this managed care 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/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 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.

1. MEMBER AND PATIENT INFORMATION (CONTINUED)

TO BE COMPLETED BY THE APPLICANT (CONTINUED)

Consent for processing my personal information (continued)

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, the undersigned, hereby declare that I have carefully read this application form, completed the applicable sections in full, and confirm that all the information provided herein is true and correct to the best of my knowledge.

Member/patient signature

- *Signature of parent/legal guardian if patient is under the age of 18*
- *Signature of legal representative, next of kin, appointed curator or power of attorney if the patient is unable to sign due to incapacity or mental and/or physical disability*

Date DD/MM/YYYY

2. MEDICAL PRACTITIONER'S INFORMATION

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER/TREATING DOCTOR

Doctor details

Practice number | Speciality

Full name and surname

Healthcare facility (if applicable) | Contact number

Physical address

Postal code

Email address

3. CLINICAL INFORMATION

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER/TREATING DOCTOR

Clinical assessment

Sex ☐ Male ☐ Female ☐ Other

Weight kg | BMI

Height cm | Waist circumference cm

Blood pressure

Initial mmHg Date DD/MM/YYYY

Present mmHg Date DD/MM/YYYY

Smoking/vaping

☐ Never

☐ Ex Started MM/YYYY Stopped MM/YYYY Average per day

☐ Present Started MM/YYYY Average per day ☐ <3 ☐ 3 - 20 ☐ >20

Exercise ☐ Never ☐ <1 hour per week ☐ 1-3 hours per week ☐ >3 hours per week

Allergies ☐ Penicillin ☐ Aspirin ☐ Sulphonamides

Other

Prescribed minimum benefit (PMB) condition(s) applied for

Diagnosis | Date of diagnosis DD/MM/YYYY

ICD-10 code | Medication name

Quantity | Strength | Number of repeats

Daily dose | Consultation or procedure code

Membership number | Doctor's practice number

3. CLINICAL INFORMATION (CONTINUED)

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER/TREATING DOCTOR (CONTINUED)

Prescribed minimum benefit (PMB) condition(s) applied for (continued)

Diagnosis				Date of diagnosis	DD/MM/YYYY
ICD-10 code		Medication name			
Quantity		Strength		Number of repeats	
Daily dose		Consultation or procedure code			

Diagnosis				Date of diagnosis	DD/MM/YYYY
ICD-10 code		Medication name			
Quantity		Strength		Number of repeats	
Daily dose		Consultation or procedure code			

Please provide additional information on complications of condition(s)

Diagnosis		Date of diagnosis	DD/MM/YYYY
ICD-10 code			

Additional clinical details

If you think your patient is at risk of having HIV or has already been diagnosed, please contact the YourLife Programme on **0860 109 793** or by email at **hiv@momentum.co.za**. All correspondence is confidential.

Application for radiology

Tariff description	Tariff code	Quantity

The quantity requested will be used as a guideline and the final approved treatment plan will be communicated to the member.

Membership number

Doctor's practice number

3. CLINICAL INFORMATION (CONTINUED)

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER/TREATING DOCTOR (CONTINUED)

Application for pathology

Tariff description	Tariff code	Quantity

The quantity requested will be used as a guideline and the final approved treatment plan will be communicated to the member.

Proposed treatment plan

Number of consultations required per annum

Frequency of pathology required per annum

Frequency of radiology required per annum

The quantity requested will be used as a guideline and the final approved treatment plan will be communicated to the member.

Supporting clinical information and motivation

Relevant medical history (other health conditions, comorbidities, onset, severity and reversibility)

Relevant family history

Lifestyle and dietary programmes details

Membership number

Doctor's practice number

3. CLINICAL INFORMATION (CONTINUED)

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER/TREATING DOCTOR (CONTINUED)

Supporting clinical information and motivation (continued)

Details of non-medication modalities to manage this patient

Chronic registration clinical criteria

Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL)	Further information/tests required
Addison's disease	Diagnosis by a specialist physician, paediatrician, endocrinologist or a healthcare provider employed by a State hospital
Asthma (adult)	Diagnosis confirmed by a GP or specialist
Asthma (child <7 years)	Diagnosis made or confirmed by specialist paediatrician
Bipolar mood disorder	A psychiatrist prescription. Benzodiazepines excluded on chronic benefit
Bronchiectasis	Diagnosis confirmed by a specialist (entry criteria for pre-existing conditions will apply e.g. COPD)
Cardiac dysrhythmia/arrhythmia (irregular heartbeat)	Diagnosis confirmed by a specialist physician
Cardiomyopathy	Diagnosis confirmed by a specialist physician
Chronic obstructive pulmonary disease (COPD)	Diagnosis confirmed by a GP or specialist. Copy of lung function test (LFT) performed to American Thoracic Society (or similar) criteria demonstrating FEV1/FVC post-bronchodilator values <70% of predicted, as per risk equalisation fund (REF) criteria
Chronic renal (kidney) disease	Diagnosis confirmed by a GP or specialist. Copy of lab results required: serum creatinine clearance value <30ml/min or a glomerular filtration rate (GFR) estimate of <30ml/min as per REF criteria
Congestive cardiac (heart) failure	Diagnosis confirmed by a specialist physician
Coronary artery (heart) disease	Diagnosis confirmed by a specialist physician
Crohn's disease	Diagnosis by a specialist physician, paediatrician, surgeon, gastroenterologist or a healthcare provider employed by a State hospital
Diabetes insipidus	Diagnosis by a specialist physician, paediatrician, neurologist, neurosurgeon, endocrinologist or a healthcare provider employed by a State hospital
Diabetes mellitus type 1	Specialist initiation and confirmatory lab results: • HbA1c >6.5% • x2 random glucose >11mmol/l • x2 fasting blood >7mmol/l • x1 blood glucose >15mmol/l • Glucose tolerance test (fasting glucose >7mmol/l and/or two hours post-prandial glucose load >11.1mmol/l)
Diabetes mellitus type 2	Diagnosis confirmed by a GP or specialist physician and confirmatory lab results as above
Epilepsy	Diagnosis confirmed by a GP, specialist physician, neurologist or neurosurgeon
Glaucoma	Diagnosis confirmed by an ophthalmologist
Haemophilia	Diagnosis confirmed by a specialist physician. Copy of lab results of factor VIII or factor IX levels <5%
Hyperlipidaemia (high cholesterol)	Diagnosis confirmed by a GP or specialist physician. Copy of lipogram results and documentation related to the Framingham Risk Score assessment. Details of patient history: established vascular disease and details of any procedure performed e.g. angioplasty, stent etc. Details of family history from prescribing doctor to include details of cardiovascular events in member's first-degree relatives, including age of onset

Membership number

Doctor's practice number

3. CLINICAL INFORMATION (CONTINUED)

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER/TREATING DOCTOR (CONTINUED)

Chronic registration clinical criteria (continued)

Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL)	Further information/tests required
Hypertension (high blood pressure)	Diagnosis by a GP or specialist physician
Hypothyroidism (underactive thyroid gland)	Diagnosis confirmed by a GP or specialist
Multiple sclerosis (MS)	Diagnosis confirmed by specialist physician, neurologist or a healthcare provider employed by a State hospital. Motivation and tick sheet to be completed by a neurologist for Betaferon®
Parkinson's disease	Diagnosis confirmed by a neurologist
Rheumatoid arthritis	Diagnosis confirmed by GP and a tick sheet to be completed, or diagnosis confirmed by a specialist physician, paediatrician or rheumatologist. We also require the following clinical information: serum rheumatoid factor (RF), anti-cyclic citrullinated peptide (anti-CCP), erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) and relevant X-rays
Schizophrenia	Diagnosis confirmed by a psychiatrist, paediatric psychiatrist or a healthcare provider employed by a State hospital
Systemic lupus erythematosus	Diagnosis by a specialist physician, paediatrician, rheumatologist or a healthcare provider employed by a State hospital
Ulcerative colitis	Diagnosis by a specialist physician, surgeon, gastroenterologist or a healthcare provider employed by a State hospital

Please ensure that prescriptions for any medication prescribed for this patient is included with this application.

Declaration by attending medical practitioner/treating doctor

I, the undersigned, hereby confirm that the diagnoses listed herein match the medication and treatment that I have prescribed. This application form accurately reflects the treatment request. I understand that approval will depend on the information provided in this application and will form the basis for future requests for this member. I confirm that the information herein has been discussed with the member and/or their parents, legal guardian or other legal representative. As the treating doctor, I acknowledge my legal responsibility for the accuracy of this application and that Momentum Health will rely on this information when recommending my patient's treatment.

I hereby declare that I have carefully read this application form, completed the applicable sections in full, and confirm that all the information provided herein is true and correct to the best of my knowledge.

Signature of attending medical practitioner/treating doctor

Date DD/MM/YYYY

transmed MEDICAL FUND

Integrated Care Programme

Telephone **0800 225 151**
Email disease@transmed.co.za
Website www.transmed.co.za

05/2025

Membership number

Doctor's practice number