Chronic Illness Benefit Application form 2019

Discovery Health Medical Scheme

Who we are

Discovery Health Medical Scheme (referred to as 'the Scheme'), registration number 1125, is the medical scheme. This is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the administrator') is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Discovery Health Medical Scheme and takes care of the administration of your membership.

Contact us

Tel (Members): 0860 99 88 77, Tel (Health partner): 0860 44 55 66, PO Box 784262, Sandton, 2146, www.discovery.co.za, 1 Discovery Place, Sandton, 2196

Purpose of form

This application form is to apply for the Chronic Illness Benefit and is only valid for 2019.

Make reference to the footnote that indicates the expiry date of the form. Download the latest version of all forms from www.discovery.co.za, under Medical Aid > Find a document

How to complete this form

- Fill in the form in black ink and print clearly, or complete the form digitally.
- All relevant sections must be physically signed and cannot be signed digitally. The patient must sign and date any changes.
- Complete and sign section 1, and fill in your details at the top of pages 4, 5, 6, 7 and 8.
- Take the application form to your doctor to complete section 2, other relevant sections, sign section 13 and attach any test results, clinical reports or other information that we need to review the request. These requirements are shown in Sections 3 and 4.
- Fax the completed application form and all supporting documents to **011 539 7000**, email it to **CIB_APP_FORMS@discovery.co.za** or post it to Discovery Health, CIB Department, PO Box 652919, Benmore, 2010.

1. Patient's details

Title _____ Initials _____ Surname _____

First name(s) (as per identity document) _____

Identity number N N N N N N N N N N N N N Gender ☐ M ☐ F Date of birth Y Y Y Y M M D D

Membership number N N N N N N N N N

Telephone (H) _____ _____ Telephone (W) _____ _____

Cellphone _____ _____ Fax _____ _____

Email _____

The outcome of this application can be communicated to me by ☐ Email ☐ Fax

I acknowledge that I have read and understood the conditions under "Member's acceptance and permission" on page 2.

Patient's signature (if patient is a minor, main member to sign) _____ Date Y Y Y Y M M D D

⚠ **Please only sign if information is true, complete and correct**

2. Doctor's details

Name and surname _____

BHF practice number N N N N N N N N N

Speciality _____

Telephone _____ _____ Fax _____ _____

Email _____

The outcome of this application can be communicated to me by ☐ Email ☐ Fax

Member's acceptance and permission

I give permission for my healthcare provider to provide Discovery Health Medical Scheme and the administrator with my diagnosis and other relevant clinical information required to review my application. 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 make informed funding decisions.

I understand that:

2.1. Funding from the Chronic Illness Benefit is subject to meeting benefit entry criteria requirements as determined by Discovery Health Medical Scheme.
2.2. The Chronic Illness Benefit provides cover for disease-modifying therapy only, which means that not all medicines for a listed condition are automatically covered by the Chronic Illness Benefit.
2.3. By registering for the Chronic Illness 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.
2.4. Funding for medicine from the Chronic Illness Benefit will only be effective from when Discovery Health Medical Scheme receives an application form that is completed in full. Please refer to the table in Sections 3 and 4 to see what additional information is required to be submitted for the condition for which you are applying.
2.5. Payment to the healthcare professional for the completion of this form, on submission of a claim, is subject to Discovery Health Medical Scheme rules and where the member is a valid and active member at the service date of the claim.

Consent for processing my personal information

I give the Scheme and the administrator consent to have access to and process all information (including general, personal, medical or clinical information) that is relevant to this application. I understand that this information will be used for the purposes of applying for and assessing my funding request for Chronic Illness Benefits. I consent to the Scheme and the administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical information) to my healthcare provider, to administer the Chronic Illness Benefits.

3. The Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions covered on all plans

Discovery Health Medical Scheme covers the following Prescribed Minimum Benefit Chronic Disease List conditions in line with legislation.

Chronic disease list condition	Benefit entry criteria requirements
Addison's disease	Application form must be completed by an endocrinologist, paediatrician (in the case of a child) or specialist physician
Asthma	None
Bipolar mood disorder	Application form must be completed by a psychiatrist
Bronchiectasis	Application form must be completed by a paediatrician (in the case of a child), pulmonologist or specialist physician
Cardiac failure	None
Cardiomyopathy	None
Chronic obstructive pulmonary disease (COPD)	1. Section 5 of this application form must be completed by the doctor 2. Please attach a lung function test (LFT) report which includes the FEV1/FVC post bronchodilator use 3. Please attach a motivation when applying for oxygen including: a. arterial blood gas report off oxygen therapy b. number of hours of oxygen use per day
Chronic renal disease	1. Section 6 of this application form must be completed by the doctor 2. Application form must be completed by a nephrologist or specialist physician 3. Please attach a supporting laboratory report reflecting creatinine clearance
Coronary artery disease	None
Crohn's disease	Application form must be completed by a gastroenterologist, paediatrician (in the case of a child), specialist physician or surgeon
Diabetes insipidus	Application form must be completed by an endocrinologist
Diabetes type 1	None
Diabetes type 2	1. Section 7 of this application form must be completed by the doctor 2. Please attach the diagnosing laboratory report
Dysrhythmia	None
Epilepsy	Application form for newly diagnosed patients must be completed by a neurologist, paediatrician (in the case of a child) or specialist physician
Glaucoma	Application form must be completed by an ophthalmologist
Haemophilia	1. Section 8 of this application form must be completed by the doctor 2. Please attach the diagnosing laboratory report reflecting factor VIII or IX levels
HIV and AIDS (antiretroviral therapy)	Please do not complete this application form for cover for HIV and AIDS. To enrol or request information on our HIVCare programme, please call 0860 100 417
Hyperlipidaemia	1. Section 9 of this application form must be completed by the doctor 2. Please attach the diagnosing laboratory report
Hypertension	Section 10 of this application form must be completed by the doctor
Hypothyroidism	1. Section 11 of this application form must be completed by the doctor 2. Please attach the diagnosing laboratory report
Multiple sclerosis (MS)	1. Application form must be completed by a neurologist 2. Please attach a report from a neurologist for applications for beta interferon indicating: a. Relapsing – remitting history b. All MRI reports c. Extended disability status score (EDSS)
Parkinson's disease	Application form must be completed by a neurologist or specialist physician
Rheumatoid arthritis	Application form must be completed by a rheumatologist, paediatrician (in the case of a child) or specialist physician

The Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions covered on all plans (continued)

Schizophrenia	Application form must be completed by a psychiatrist
Systemic lupus erythematosus	Application form must be completed by a nephrologist, paediatrician (in the case of a child), pulmonologist, rheumatologist, or specialist physician
Ulcerative colitis	Application form must be completed by a gastroenterologist, paediatrician (in the case of a child), specialist physician or surgeon

4. The Additional Disease List (ADL) conditions covered on Executive and Comprehensive Plans

If you are on an Executive or Comprehensive Plan you have cover for all the chronic conditions in the Additional Diseases List below. Your cover is subject to benefit entry criteria.

Additional disease list	Benefit entry criteria requirements
Ankylosing spondylitis	Application form must be completed by a rheumatologist or specialist physician
Behcet's disease	Application form must be completed by a rheumatologist or specialist physician
Cystic fibrosis	Application form must be completed by a paediatrician (in the case of a child), pulmonologist, or specialist physician
Delusional disorder*	Application form must be completed by a psychiatrist
Dermatopolymyositis	Application form must be completed by a dermatologist, rheumatologist or specialist physician
Generalised anxiety disorder*	Applications for first line therapy will be accepted from GPs for 6 months only. Psychiatrist motivation is required for further cover
Huntington's disease	Application form must be completed by a neurologist or psychiatrist
Isolated growth hormone deficiency in children under 18 years	1. Application form must be completed by an endocrinologist or paediatrician. 2. Please attach the relevant laboratory results and growth chart
Major depression*	Applications for first line therapy will be accepted from GPs for 6 months only. Psychiatrist motivation is required for further cover
Motor neurone disease	None
Muscular dystrophy and other inherited myopathies*	None
Myasthenia gravis*	None
Obsessive compulsive disorder	Application form must be completed by a psychiatrist
Osteoporosis	1. Section 12 of this application form must be completed by the doctor 2. Application form must be completed by an endocrinologist for patients <50 years of age 3. Please attach the diagnosing DEXA bone mineral density scan (BMD) report
Paget's disease	Application form must be completed by a paediatrician (in the case of a child) or specialist physician
Panic disorder	Applications for first line therapy will be accepted from GPs for 6 months only. Psychiatrist motivation is required for further cover
Polyarteritis nodosa	Application form must be completed by a rheumatologist
Post-traumatic stress disorder*	Application form must be completed by a psychiatrist
Psoriatic arthritis	Application form must be completed by a rheumatologist or specialist physician
Pulmonary interstitial fibrosis	Application form must be completed by a paediatrician (in the case of a child), pulmonologist or specialist physician
Sjogren's syndrome	Application form must be completed by a rheumatologist or specialist physician
Systemic sclerosis	Application form must be completed by a rheumatologist or specialist physician
Wegener's granulomatosis	Application form must be completed by a paediatrician (in the case of a child), rheumatologist or specialist physician

* Although these Diagnostic Treatment Pair Prescribed Minimum Benefit (DTP PMB) conditions are covered on all plan types, the PMB cover does not extend to medicine management. They are included on the Additional Disease List to allow funding for medicines for members on the Executive and Comprehensive Plans.

Patient name and surname _____

Membership number | N | N | N | N | N | N | N | N | N |

5. Application for chronic obstructive pulmonary disease (to be completed by doctor)

If the patient meets the requirement shown below, chronic obstructive pulmonary disease will be approved for funding from the Chronic Illness Benefit.

Please attach the initial or diagnostic lung function test report which shows an FEV1/FVC post bronchodilator reading of <70%

6. Application for chronic renal disease (to be completed by doctor)

If the patient meets the requirements listed in either A or B below, chronic renal disease will be approved for funding from the Chronic Illness Benefit.
Please tick the ☐ to indicate yes

A. Previously diagnosed patients

☐ The patient has been diagnosed with chronic renal disease and is undergoing dialysis

B. Please attach a laboratory report that shows a creatinine clearance of <60 ml/min

7. Application for diabetes type 2 (to be completed by doctor)

If the patient meets the requirements listed in either A, B or C below, diabetes type 2 will be approved for funding from the Chronic Illness Benefit.
Please tick the ☐ to indicate yes

A. Type 2 diabetic on Insulin

☐ The patient is a type 2 diabetic on insulin

B. Please attach the initial or diagnostic laboratory results that confirm the diagnosis of diabetes type 2
Please note that finger prick and point of care tests are not accepted for registration on the Chronic Illness Benefit.

Do these results show **one** of the following:

☐ A fasting plasma glucose concentration ≥ 7.0 mmol/l

☐ A random plasma glucose ≥ 11.1 mmol/l

☐ A 2-hour post-load glucose ≥ 11.1 mmol/l during an oral glucose tolerance test (OGTT)

☐ An HbA1C ≥ 6.5%

C. Initial or diagnostic laboratory test results are not available

☐ The patient was diagnosed with diabetes type 2 more than five years ago and the initial or diagnostic laboratory results are not available

Important: please note that no exceptions will be made for patients being treated with Metformin monotherapy.

8. Application for haemophilia (to be completed by doctor)

If the patient meets either of the requirements listed below, haemophilia will be approved for funding from the Chronic Illness Benefit.
Please tick the ☐ to indicate yes

Please attach the initial or diagnostic laboratory results that confirms the diagnosis of haemophilia

Do the results show **one** of the following:

☐ A factor VIII level of <5%

☐ A factor IX level of <5%

Patient name and surname _____

Membership number | N | N | N | N | N | N | N | N | N |

9. Application for hyperlipidaemia (to be completed by doctor)

If the patient meets the requirements listed in either A, B, or D below, hyperlipidaemia will be approved for funding from the Chronic Illness Benefit. Information provided in section C will be reviewed on an individual basis.

Please tick the ☐ to indicate yes

A. Primary prevention

Please attach the initial or diagnostic laboratory results that confirms the diagnosis of hyperlipidaemia.

Please use the Framingham 10-year risk Assessment Chart to determine the absolute 10-year risk of a coronary event **(2012 South Africa Dyslipidaemia Guideline)** and indicate if the patient:

☐ Has a risk of 20% or greater **or**

☐ Has a risk of 30% or greater when extrapolated to age 60

Please indicate if the patient is:

☐ A smoker or has ever been a smoker

☐ On treatment for Hypertension

Please supply the patient's current blood pressure reading _____ / _____ mmHg

Familial hyperlipidaemia

☐ The patient was diagnosed with homozygous or heterozygous familial hyperlipidaemia and the diagnosis was confirmed by an endocrinologist, lipidologist or lipid clinic.

Please attach supporting documentation.

B. Secondary prevention

Please indicate if the patient has/has had a history of **one** of the following:

☐ Diabetes type 2
☐ Stroke
☐ TIA
☐ Coronary artery disease
☐ Any vasculitides where there is associated renal disease (Please attach the supporting laboratory report reflecting creatinine clearance)
☐ Solid organ transplant (Please supply the relevant clinical information in Section C)
☐ Chronic renal disease (Please attach the supporting laboratory report reflecting creatinine clearance)
☐ Peripheral arterial disease (Please attach the doppler ultrasound or angiogram)
☐ Diabetes type 1 with microalbuminuria or proteinuria (Please attach the supporting laboratory report)

C. Please supply any other relevant clinical information about this patient that supports the diagnosis of hyperlipidaemia

_____

_____

D. Initial or diagnostic laboratory test results are not available

☐ The patient was diagnosed with hyperlipidaemia more than five years ago and the initial or diagnostic laboratory results are not available

Patient name and surname _____

Membership number | N | N | N | N | N | N | N | N | N |

10. Application for hypertension (to be completed by doctor)

If the patient meets the requirements listed in either A, B or C below, hypertension will be approved for funding from the Chronic Illness Benefit.

Please tick the ☐ to indicate yes

A. Previously diagnosed patients

☐ The diagnosis was made more than six (6) months ago and has the patient been on treatment for at least that period of time

B. Please indicate if the patient has/has had a history of one of the following:

☐ Chronic renal disease
☐ Stroke
☐ Peripheral arterial disease
☐ Myocardial infarction
☐ Coronary artery disease
☐ Prior CABG
☐ Hypertensive retinopathy
☐ Pre-eclampsia
☐ TIA

C. Newly diagnosed patients

The diagnosis was made within the last six (6) months and the patient has a:

☐ Blood pressure ≥ 130/85 mmHg and patient has diabetes or congestive cardiac failure or cardiomyopathy
☐ Blood pressure ≥ 160/100 mmHg
☐ Blood pressure ≥ 140/90 mmHg on two or more occasions, despite lifestyle modification for at least 6 months
☐ Blood pressure ≥ 130/85 mmHg and the patient has target organ damage indicated by:

- Left ventricular hypertrophy or
- Microalbuminuria or
- Elevated creatinine

11. Application for hypothyroidism (to be completed by doctor)

If the patient meets the requirements listed in either A, B or C below, hypothyroidism will be approved for funding from the Chronic Illness Benefit.

Please tick the ☐ to indicate yes

A. Please specify the relevant clinical information. The patient:

☐ Has had a Thyroidectomy
☐ Has been treated with radioactive iodine
☐ Has been diagnosed with Hashimoto's Thyroiditis

B. Please attach the initial or diagnostic laboratory results that confirm the diagnosis of hypothyroidism, including TSH and T4 levels.

Do these results show:

☐ A raised TSH and reduced T4 level
☐ A raised TSH but normal T4 level and higher than normal thyroid antibodies
☐ A raised TSH level of greater than 10 mIU/l on two or more occasions at least three months apart in a patient with normal T4 levels

C. Initial or diagnostic laboratory test results are not available

☐ The patient was diagnosed with hypothyroidism more than five years ago and the initial or diagnostic laboratory results are not available

Patient name and surname _____

Membership number | N | N | N | N | N | N | N | N | N |

12. Application for osteoporosis (to be completed by doctor)

If the patient meets the requirements listed in either A, B or C below, osteoporosis will be approved for funding from the Chronic Illness Benefit.

Please tick the ☐ to indicate yes

A. Osteoporotic fracture

☐ The patient has been diagnosed with an osteoporotic fracture of the spine, forearm, hip or shoulder

B. Spinal wedging

☐ The patient has spinal wedging

Please indicate the number of wedges_____

C. Please attach the diagnosing DEXA bone mass density scan results that confirm the diagnosis of osteoporosis

Do these results show:

☐ T-score of the AP Spine is <= -2.5

☐ T-score of the right hip is <= -2.5

☐ T-score of the left hip is <= -2.5

☐ T-score of the right femoral hip is <= -2.5

☐ T-score of the left femoral hip is <= -2.5

Patient name and surname

Membership number | N | N | N | N | N | N | N | N | N |

13. Medicine required (to be completed by doctor)

Formulary medicine will be funded up to the Discovery Health Rate. There will be no co-payment for medicine selected from the formulary.

For non-formulary medicine, we fund up to the Chronic Drug Amount (CDA), which is a monthly amount we pay up to, for a specific medicine class. The member may be liable for a co-payment where the cost of the medicine is greater than the CDA (not applicable for Smart and KeyCare plans).

ICD-10 code	Condition description	Date when condition was first diagnosed	Medicine name, strength and dosage	How long has the patient used this medicine?	
				Years	Months

Notes to doctors

13.1. The doctor's fee for completion of this form will be reimbursed on code 0199, on submission of a separate claim. Payment of the claim is subject to Discovery Heath Medical Scheme rules and where the member is a valid and active member at the service date of the claim.

13.2. In line with legislative requirements, please ensure that when using code 0199, you submit the ICD-10 diagnosis code(s). As per industry standards, the appropriate ICD-10 code(s) to use for this purpose would be those reflective of the actual chronic condition(s) for which the form was completed. If funding for multiple chronic conditions were applied for, then it would be appropriate to list all the relevant ICD-10 codes.

13.3. We will approve funding for generic medicine, where available, unless you have indicated otherwise.

13.4. Please submit all the requested supporting documents with this application to prevent delays in the review process.

13.5. An application form only needs to be completed when applying for a **new chronic condition.** You can Email a **prescription** for changes to your patient's treatment plan for an approved condition. You can also complete and submit an application form for a new condition as well as make changes to your patient's treatment plan through **HealthID**, provided that your patient has given consent.

Signature of doctor

Date | Y | Y | Y | Y | M | M | D | D |

⚠ **Please only sign if information is true, complete and correct.**