Administered by Discovery Health

Contact details
Tel: 0860 101 252 • PO Box 652509, Benmore 2010 • www.retailmedicalscheme.co.za

Chronic Illness Benefit application form

This application form is to apply for the Chronic Illness Benefit

The latest version of the application form is available on www.retailmedicalscheme.co.za. Alternatively members can phone 0860 101 252 and health professionals can phone 0860 44 55 66.

Who we are

Retail Medical Scheme (referred to as 'the Scheme'), registration number 1176, is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as 'the Administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). Discovery Health (Pty) Ltd administers Retail Medical Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. You (the member) must complete and sign Section 1 of this form.
3. Your doctor must complete Section 2, other relevant sections, sign section 7 and attach any test results, clinical reports or other information that we need to review the request. These requirements are shown in Section 3.
4. Please email this completed and signed form with supporting documents to **CIB_APP_FORMS@retailmedicalscheme.co.za** or post it to Retail Medial Scheme, CIB Department, PO Box 652919, Benmore, 2010.

1. Patient's details

Title | Initials

First name(s)

Surname

ID or passport number | Membership number

Telephone (H) | Cellphone

Email address

The outcome of this application will be communicated to you by email.

I give consent to Discovery Health (Pty) Ltd and Retail Medical Scheme to use the above communication channel for all future communication.

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 D D M M Y Y Y Y

Member's acceptance and permission

I give permission for my healthcare provider to provide Retail Medical Scheme and Discovery Health (Pty) Ltd with my diagnosis and other relevant clinical information required to review my application. I agree to give permission for you to collect and record information about my condition and treatment, this will also be used to develop registries. This data will be analysed, evaluated and used to measure clinical outcomes and make informed funding decisions.

I understand that:

1.1. Funding from the Chronic Illness Benefit is subject to meeting benefit entry criteria requirements as determined by Retail Medical Scheme.

1.2. 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.

1.3. 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.

1.4. Funding for medicine from the Chronic Illness Benefit (CIB) will only be effective from when Retail Medical Scheme receives an application form that is completed in full. I can refer to the table in Section 3 to see what additional information is required to be submitted for the condition for which I am applying.

1.5. A new Chronic Illness Benefit application form needs to be completed when applying for a new chronic condition.

1.6. If I am approved on the benefit, I need to let Retail Medical Scheme and the Administrator know when my treating doctor changes my treatment plan so my chronic authorisation/s can be updated. I can do this by emailing the new prescription to the email provided or asking my doctor or pharmacist to do this for me. Alternatively, my doctor can log onto HealthID to make the changes, provided that I have given consent. If I do not let Retail Medical Scheme and the Administrator know about changes to my treatment plan, my claims may not be paid from the correct benefit.

1.7. To make sure that my claims are paid from the correct benefit, the claims from my doctors must be submitted with the relevant ICD-10 diagnosis code(s). I must ask my doctor to include my ICD-10 diagnosis code(s) on the claims they submit and on the form that they complete when they refer me to pathologists and radiologists for tests. This will enable pathologists and radiologists to include the relevant ICD-10 diagnosis code(s) on the claims they submit, ensuring my claims are paid from the correct benefit.

Consent for processing my personal information

I give Retail Medical 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 and to relevant third parties, to administer the Chronic Illness Benefits as well as undertake managed care interventions related to the chronic condition.

Consent withdrawal for your Chronic Illness Benefit (CIB)
Withdrawing consent for your general, personal, medical or clinical information to be accessed or shared with relevant third parties, means that you will no longer have access to funding from the applicable Chronic Illness Benefits. Claims which would usually be funded from the Chronic Illness Benefits will, once consent is withdrawn, be funded from other available benefits according to the rules of your benefit option. Should you wish to continue with the consent withdrawal process, then please email **CIB_APP_FORMS@retailmedicalscheme.co.za**.

2. Doctor's details

Name and surname			
Practice number		Speciality	
Telephone			
Email			

The outcome of this application will be communicated to you by email.

3. The Chronic Disease List (CDL) conditions covered on Essential and Essential Plus Options

The following Chronic Disease List (CDL) conditions are covered by Retail Medical Scheme in line with legislation.

Your cover is subject to benefit entry criteria. Approval on the Chronic Illness Benefit for your CDL condition(s) offers cover for medicine and treatment baskets for the management of your condition(s). Please refer to the **website** for more information on what is covered on the benefit and how it is covered.

Chronic disease list condition	Benefit entry requirements
Addison's disease	Application form must be completed by a paediatrician (in the case of a child), endocrinologist 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. Please attach a lung function test (LFT) report that includes the FEV1/FVC post bronchodilator use 2. Please attach additional information 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. Application form must be completed by a nephrologist or specialist physician 2. Please attach a diagnosing laboratory report reflecting creatinine clearance
Coronary artery disease	None
Crohn's disease	Application form must be completed by a paediatrician (in the case of a child), gastroenterologist, specialist physician or surgeon
Diabetes insipidus	Application form must be completed by an endocrinologist or specialist physician
Diabetes type 1	None
Diabetes type 2	1. Section 6 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, specialist physician or paediatrician (in the case of a child)
Glaucoma	Application form must be completed by an ophthalmologist
Haemophilia	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 101 252.
Hyperlipidaemia	1. Section 4 of this application form must be completed by the doctor 2. Please attach the diagnosing laboratory report
Hypertension	None
Hypothyroidism	1. Section 5 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
Schizophrenia	Application form must be completed by a psychiatrist
Systemic lupus erythematosus	Application form must be completed by a paediatrician (in the case of a child), rheumatologist, nephrologist, pulmonologist or specialist physician
Ulcerative colitis	Application form must be completed by a paediatrician (in the case of a child), gastroenterologist, specialist physician or surgeon

4. Application for hyperlipidaemia (to be completed by Doctor)

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

A. Primary Prevention

Please **attach the diagnosing lipogram**

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

Is the patient a smoker or has the patient ever been a smoker? Yes ☐ No ☐

Please use the Framingham 10-year Risk Assessment Chart as per the 2018 South African Dyslipidaemia Guidelines to determine the absolute 10-year risk of a coronary event and indicate:

Does the patient have a risk of 20% or greater Yes ☐

OR

Is the risk 30% or greater when extrapolated to age 60 Yes ☐

B. Familial hyperlipidaemia

Please **attach the diagnosing lipogram**

Was the patient diagnosed with homozygous familial hyperlipidaemia and was the diagnosis confirmed by an endocrinologist or lipidologist? Yes ☐

Please attach supporting documentation.

OR

Was the patient diagnosed with heterozygous familial hyperlipidaemia and was the diagnosis confirmed by a specialist? Yes ☐

Please attach supporting documentation.

C. Secondary prevention

Please indicate what your patient has:

Diabetes type 2 ☐

Stroke ☐

TIA ☐

Coronary artery disease ☐

Chronic kidney disease. Please supply the diagnosing laboratory report reflecting creatinine clearance ☐

Peripheral arterial disease. Please supply the doppler ultrasound or angiogram ☐

Diabetes type 1 with microalbuminuria or proteinuria ☐

Any vasculitides where there is associated renal disease. Please supply the diagnosing laboratory report reflecting creatinine clearance ☐

Solid organ transplant. Please supply the relevant clinical information in Section D ☐

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

E. Was the patient diagnosed with hyperlipidaemia more than five (5) years ago and the laboratory results are not available? Yes ☐

5. Application for hypothyroidism (to be completed by Doctor)

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

A. Thyroidectomy: Please indicate whether your patient has had a thyroidectomy Yes ☐

B. Radioactive iodine: Please indicate whether your patient has been treated with radioactive iodine Yes ☐

C. Hashimoto's thyroiditis: Please indicate whether your patient has been diagnosed with Hashimoto's thyroiditis Yes ☐

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

Was the diagnosis based on the presence of **clinical symptoms and one of the following:**

A raised TSH and reduced T4 level Yes ☐

OR

A raised TSH but normal T4 level and higher than normal thyroid antibodies Yes ☐

OR

A raised TSH level of greater than or equal to 10 mIU/l on two (2) or more occasions at least three (3) months apart in a patient with a normal T4 level Yes ☐

E. Was the patient diagnosed with hypothyroidism more than five (5) years ago and the laboratory results are not available? Yes ☐

6. 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.

A. 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:

A fasting plasma glucose concentration ≥ 7.0 mmol/l Yes ☐

OR

A random plasma glucose ≥ 11.1 mmol/l Yes ☐

OR

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

OR

An HbA1C ≥ 6.5% Yes ☐

B. Is the patient a type 2 diabetic on insulin? Yes ☐

C. Was the patient diagnosed with diabetes type 2 more than five (5) years ago and the laboratory results are not available? Yes ☐

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

7. Medicine required (to be completed by Doctor)

To assist us in paying claims for the diagnosis of condition(s) from the correct benefits, please ensure that you include the **date when the condition was first diagnosed** in the table below.

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

Notes to Doctor

7.1. To assist us in paying claims from the correct benefits, please ensure that the date on which the condition was first diagnosed is stipulated in the table above.

7.2. Please ensure that the relevant ICD-10 diagnosis code(s) are used when you submit your claims to the Scheme to ensure payment from the correct benefit.

7.3. Please include the ICD-10 diagnosis code(s) when referring your patient to pathologists and radiologists. This will enable pathologists and radiologists to include this information on their claims and allow us to comply with legislation by paying Prescribed Minimum Benefits (PMB) claims correctly.

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

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

7.6. Should you make changes to your patient's treatment plan, you need to let us know so that we can update their chronic authorisation/s. You can do this by emailing the new prescription to us or by logging onto HealthID to make the changes, provided that the patient has given consent. If you or your patient do not let us know about changes to the treatment plan, we may not pay claims from the correct benefit.

Doctor's signature

Date D D M M Y Y Y Y