

Identity Number

CONDITION INFORMATION

Have you or any of your dependants ever experienced or been treated for, or are currently suffering from any of the following conditions?
If Yes, Please tick the appropriate block or specify the conditions, and complete page 5

1. Cardiovascular and or Blood disorders

Chest Pain (Angina) Valve defect Rheumatic heart disease Heart attack
 Murmurs Hypertension (Blood pressure) Arrhythmia Hypercholestromia
 Anemia Leukemia

Other, Specify

2. Respiratory problems (Lungs or breathing)

Difficulty in breathing Shortness of breath Persistent cough Asthma
 Croup Tuberculosis Bronchitis Pneumonia
 Coughing up blood

Other, Specify

3. Ear, Nose & Throat

Hearing/speech impairment Ear Infections Sinus problems Allergic rhinitis

Other, Specify

4. Kidney / Urinary System

Blood in urine Kidney infections Prostate conditions Kidney failure
 Kidney stones Congenital urinary conditions Recurrent urinary tract infections

Other, Specify

5. Gynaecological

Ovarian cysts Endometriosis Abnormal pap smears Fibroid
 Enlarged uterus Menstrual disorders Pregnant at present

Other, Specify

6. Glandular/ Endocrine

Diabetes Mellitus Addison's disease Cushing's syndrome Growth disorders
 Disorders of the pituitary gland Hypo/hyperactive thyroid gland

Other, Specify

7. Neurological (Nervous system)

Paralysis Stroke Epilepsy Migraine
 Brain or spinal cord disorder Multiple sclerosis

Other, Specify

8. Gastrointestinal

Malena Stools (Bleeding) Ulcers Jaundice Change in bowel habits
 Pancreatic disorders Colitis Gall Stones/Cholecystitis Pancreatic disorders
 Irritable bowel syndrome

Other, Specify

9. Musculoskeletal

Joint or spine condition, including Rheumatoid/Osteo-arthritis Neck or Back problems
 Recurrent back pain Ankylosing Spondylitis Osteoporosis

Other,Specify

10. Lumps or Growths

Benign tumours Malignant tumours Lymph cancer
 Melanoma

Other, Specify

11. Emotional / Psychological

Anxiety Depression Schizophrenia Attention deficit disorder
 Anorexia Anorexia or any other eating disorders Alzheimers disease Bi-polar disorders

Other, Specify

12. Eyes

Glaucoma Blindness Impaired vision Retinitis
 Conjunctivitis Macular degeneration Cataract

Other, Specify

Have you ever had, or are you currently undergoing or anticipating any specialised dentist treatment? (e.g. Orthodontic treatment or impacted wisdom teeth) Yes No

Do you have any congenital, hereditary or physical disability? Yes No

Do you participate in any hazardous sports or pursuits e.g. mountain climbing, paragliding? Yes No

Are you aware of any other conditions which may not have been specified on this form? Yes No



CHRONIC MEDICATION BENEFIT APPLICATION FORM

CALL CENTRE: 041-395 4400 | P.O. Box 1672 | 68 Cape Road
 E-MAIL ADDRESS: info@providence.co.za | Port Elizabeth | Port Elizabeth
 WEB ADDRESS: medimed@providence.co.za | 6001 | 6000

Administered and Managed by PROVIDENCE Healthcare Risk Managers

A. IMPORTANT INFORMATION

- One application must be completed per beneficiary applying for chronic medication.
- Allow 5 working days for the processing of your application.
- The original prescription must be given to the provider who dispenses your medication.
- It is essential that you submit all required information correctly and timeously as incomplete forms will not be processed.
- Approval of chronic medication is subject to the rules of the Scheme and PROVIDENCE Chronic Protocols
- You may contact the Pharmacy Benefit Management (PBM) Team at (041) 395 4482 or email pbm@providence.co.za.
- Send completed forms via fax 086 680 8855, mail PO Box 1672, Port Elizabeth, 6000 or e-mail pbm@providence.co.za.

B. MEMBER DETAILS

Scheme	<input type="text"/>	Option	<input type="text"/>
Membership Number	<input type="text"/>		
Surname	<input type="text"/>	First Names	<input type="text"/>
Title	<input type="text"/>	Date of Birth	<input type="text"/>
Telephone number (Home)	<input type="text"/>	ID Number	<input type="text"/>
Fax number (Confidential)	<input type="text"/>	(Work)	<input type="text"/>
Email address (Confidential)	<input type="text"/>		
Postal Address	<input type="text"/>		
	<input type="text"/>	Code	<input type="text"/>

C. PATIENT DETAILS (Beneficiary who requires Chronic Medication)

Surname	<input type="text"/>	First Names	<input type="text"/>
Title	<input type="text"/>	Date of Birth	<input type="text"/>
Telephone number (Home)	<input type="text"/>	ID Number	<input type="text"/>
Fax number (Confidential)	<input type="text"/>	(Work)	<input type="text"/>
Email address (Confidential)	<input type="text"/>		
	<input type="text"/>	Cellular	<input type="text"/>

The outcome of this application must be communicated to me via my email address: Yes No OR fax number Yes No

D. PATIENT DECLARATION

- By signing below, I hereby give permission for, acknowledge and/or agree to the following:**
- My (or my minor dependant's) doctor may provide clinical information regarding my/minor's condition to the PBM Team;
 - Any information concerning this application will remain confidential at all times;
 - It may be a pre-condition to the approval of the Chronic Medication Benefit that I register and comply with the requirements of a Disease Management Programme and that non-compliance may lead to the withdrawal of this benefit;
 - My (or my minor dependant's) doctor retains the responsibility for my (or my minor dependant's) condition, based on the understanding that I (or my minor dependant) also has a responsibility towards my (or my minor dependant's) own health concerns, irrespective of the outcome of this application.
 - This funding authorisation is at all times subject to the Scheme rules even if a member's circumstances change after the authorisation is provided. This authorisation is not a guarantee of payment.
 - This funding authorisation is based on the most appropriate clinical criteria in terms of the Scheme rules and protocols. All treatment decisions remain the responsibility of the of the beneficiary's health care provider irrespective of the funding decision made in terms of the Scheme rules, clinical criteria and protocols.
 - PROVIDENCE shall not accept responsibility for any act, errors or omissions, loss, damage or consequences of individual responses to to the treatment authorised or not authorised for funding by the Scheme.

Patient Signature (or member if patient is a minor) _____ Date

E. PATIENT HEALTH INFORMATION (to be completed by doctor)

Weight	<input type="text"/> kg	Height	<input type="text"/> m	Hip/Waist ratio	<input type="text"/>	Smoker?	<input type="checkbox"/> Y <input type="checkbox"/> N	Ave per day	<input type="text"/>
Exercise: Frequency	<input type="text"/> X per week	Intensity (Please tick)	Low	<input type="checkbox"/>	Medium	<input type="checkbox"/>	High	<input type="checkbox"/>	
Current blood pressure	<input type="text"/> mmHg	Fasting Blood Glucose (If available)	<input type="text"/> mmol/L						

Patient name

Membership number

F. CLINICAL CRITERIA

The following information is required when applying for a new chronic condition

Certain conditions which do not appear on the form below may be considered for approval on the Chronic Benefit, although not all long-term conditions, which a doctor may define as chronic, will fulfill the criteria for approval.

* Chronic conditions only available on the Extended Chronic Benefit of the Medisave Max, Medisave Standard and Medimed Alpha options. Not applicable to Managed Care options.

Condition	Requirements
Addison's Disease	1. Serum Cortisol Test. 2. ACTH Stimulation Test. 3. Initial Specialist Application.
ADHD *	1. Initial Specialist Application . 2. Motivation if > 12 years.
Alzheimer's Disease*	1. Folstein's Mini Mental Examination State (MMSE) result. 2. Initial Specialist Application.
Ankylosing Spondylitis	1. Initial Specialist Application .
Asthma	1. Lung function test (8 yrs and older).
Benign Prostatic Hypertrophy*	1. Motivation for 2nd line agents (E.g. Avodart®, Flomax® and Xatral®).
Bipolar Mood Disorder	1. Specialist to complete Section J.
Bronchiectasis	1. Attach relevant radiology report. 2. Initial Specialist Application.
Cardiac failure	1. Please classify according to NYHA or ACC-AHA Classification. 2. Details of diagnosing specialist to be supplied.
Cardiomyopathy	1. Details of diagnosing specialist to be supplied.
Chronic Obstructive Pulmonary Disease	1. Lung function test including FEV1/FVC and FEV1 post bronchodilator.
Chronic Renal Disease	1. Serum Creatinine Clearance. 2. Initial Specialist (Nephrologist) Application.
Coronary Artery Disease	1. Stress ECG confirming diagnosis. 2. Attach history of previous cardiovascular disease event(s).
Crohn's Disease	1. Details of diagnosing specialist to be supplied.
Cystic Fibrosis	1. Details of diagnosing specialist to be supplied.
Depression*	1. Funding for first line therapy will be allowed for 6 months only. Further funding will only be considered on motivation from a psychologist and/or prescription from a psychiatrist. 2. Prescriber to complete Section J.
Diabetes Insipidus	1. Water deprivation test results. 2. Initial Specialist Application.
Diabetes Mellitus	1. Attach initial diagnostic report.
Dysrhythmias	1. Prescriber to clearly indicate ICD-10 code.
Epilepsy	1. EEG report confirming diagnosis. 2. Attach detailed seizure history .
Generalised Anxiety Disorder*	1. Specialist motivation required for treatment exceeding a 6 month period.
Glaucoma	1. Supply initial diagnostic intra-ocular pressure.
GORD*	1. Diagnostic Gastroscopy or Barium Meal Swallow report.
Haemophilia	1. Haemophilia A (Factor VIII as % of Normal). 2. Haemophilia B (Factor IX as % of Normal).
Hyperlipidaemia	1. Prescriber to complete Section G and I. 2. Please attach the diagnosing lipogram. The application cannot be reviewed if this is not submitted.
Hypertension	1. Prescriber to complete Section G and H. 2. Initial Specialist Application if younger than 30 years.
Hyperthyroidism	1. Attach report showing T3, T4 and TSH levels.
Hypothyroidism	1. Attach initial diagnostic report.
Menopause*	1. Motivation required for early-onset menopause (< 40yrs) and the prescription of Livifem ®.
Multiple Sclerosis	1. Extended Disability Status Score (EDSS). 2. Comprehensive disease history. 3. Initial Specialist Application.
Osteoporosis*	1. DEXA bone mineral density (BMD) scan and report on any additional risk factors.
Parkinson's Disease	1. Initial Specialist Application.
Rheumatoid Arthritis (RA)	1. Initial diagnostic test results confirming RA may be required where a "stepped therapy" approach has not been implemented. 2. Initial Specialist Application and motivation For Enbrel® and Revellex®.
Schizophrenia	1. Psychiatrist to complete Section J.
Systemic Lupus Erythematosus	1. Initial Specialist Application.
Ulcerative Colitis	1. Details of diagnosing specialist to be supplied.

