Discovery Health

Contact us
Tel: 0860 99 88 77, PO Box 784262, Sandton, 2146, www.discovery.co.za

Chronic Illness Benefit application form 2009

This application form is to apply for the Chronic Illness Benefit and is only valid for 2009.

The latest version of the application form is available on www.discovery.co.za. Alternatively members can phone 0860 99 88 77 and health professionals can phone 0860 44 55 66.

Fax the completed application form to (011) 539 7000, email it to CIB_APP_FORMS@discovery.co.za
or post it to CIB Department, Discovery Health, PO Box 652919, Benmore 2010.

What you must do
Please go through these steps:
Step 1: Fill in and sign the application form (section 1), and fill in your details on the top of page 4 and 5.
Step 2: Take the application form to your doctor.

The scheme has the right to change the rules for membership from time to time. You may ask us for a copy of them at any time. When you sign this application, you confirm that you have read and understood the rules and that you agree that you and those you apply for will be bound by them.
If you have any questions, please let us or your financial adviser know. Once we have assessed your application, we will let you know.

1. Important patient information (to be completed by the member)

Title ____ Surname ____

First names ____

Sex M F Identity number ____ Member number ____

Telephone ____ Home ____

Cellular ____ Fax ____

Email address ____

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

I hereby give permission for my doctor to provide Discovery Health with my diagnosis and other relevant clinical information required to review my application for the Chronic Illness Benefit. I understand that funding from the Chronic Illness Benefit is subject to clinical entry criteria and drug utilisation review as determined by Discovery Health.

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. 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. I understand that non-compliance may lead to the withdrawal of this benefit.

Should your application for the Chronic Illness Benefit be declined, you may choose to pay for your medicine out of your Medical Savings Account (not applicable to Core and KeyCare members), subject to the availability of funds and Discovery Health rules. Medicine approved by the Chronic Illness Benefit will only be effective from date of receipt of an application form that is completed in full.

The covered Chronic Illness Benefit conditions and clinical entry criteria may change from time to time and you may be required to submit an updated/new application form if requested by Discovery Health and/or the Scheme.

I hereby authorise both Discovery Health and the Scheme to obtain any medical information or any other information pertaining to my dependants or myself that I may have disclosed to any entity in the Discovery Group and to utilise such information for underwriting or any risk management purposes.

I hereby give my consent that Discovery Health and/or the Scheme may, from time to time, disclose any information supplied to Discovery Health – including general or medical information – to my appointed healthcare intermediary or any other third party. I agree that Discovery Health may disclose this information at its sole discretion, but only as long as all the parties involved have agreed to keep the information confidential at all times.

Signed principal member ____ Patient (unless a minor) ____

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2. The Prescribed Minimum Benefits (PMB) (for members on Executive, Comprehensive, Priority, Saver, Core and KeyCare Plans)

For information only. Do not fax this page to Discovery Health. Discovery Health covers the following 27 Chronic Disease List Prescribed Minimum Benefit conditions (CDL PMBs), in line with legislation on all plan types.

PMB CONDITION	CLINICAL ENTRY CRITERIA (CEC) REQUIREMENTS
Addison's disease	Application form must be completed by a paediatrician or endocrinologist.
Asthma	The South African Treatment Guidelines for Asthma, as published in the SAMJ are applied to all applications.
Bipolar Mood Disorder	Application form must be completed by a psychiatrist.
Bronchiectasis	Application form must be completed by a paediatrician or pulmonologist.
Cardiac failure	None
Cardiomyopathy	None
Chronic obstructive pulmonary disease (COPD)	1. Please attach a lung function test (LFT) report which includes the FEV1/FVC and FEV1 post bronchodilator use. 2. Please attach a motivation from a specialist when applying for oxygen including: a. oxygen saturation levels off oxygen therapy b. number of hours of oxygen use per day c. FEV1 level
Chronic renal disease	1. Application form must be completed by a nephrologist. 2. Please attach a diagnosing laboratory report reflecting creatinine clearance. 3. Please attach a report reflecting haemoglobin or haematocrit levels when applying for erythropoietin, indicating if the results are on or off drug therapy.
Coronary artery disease	Please provide details of history of previous cardiovascular disease or event(s) in patient, if applicable.
Crohn's disease	1. Application form must be completed by a gastroenterologist. 2. This application form is not applicable for biologics (eg Revellex®). Call 0860 99 88 77 or visit www.discovery.co.za to request the relevant application form, which must be completed by a gastroenterologist. Please note that biologics are only covered on Executive and Comprehensive Plans.
Diabetes insipidus	Application form must be completed by an endocrinologist.
Diabetes Type 1	None
Diabetes Type 2	Refer to Section 6
Dysrhythmias	None
Epilepsy	Application form 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 a 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 HIV*Care* programme, please call 0860 100 417
Hyperlipidaemia	Section 5 must be completed by the doctor.
Hypertension	Section 4 must be completed by the doctor.
Hypothyroidism	1. Please attach the initial or diagnostic laboratory report that confirms the diagnosis of hypothyroidism, including TSH and T4 blood levels. 2. Please indicate if the patient had a thyroidectomy.
Multiple sclerosis (MS)	1. Application form must be completed by a neurologist. 2. Please attach a report from a neurologist for applications for interferon indicating: a. Relapsing – remitting history b. Relapses requiring treatment with IV cortisone c. Extended disability status score (EDSS)
Parkinson's disease	Application form must be completed by a neurologist.
Rheumatoid arthritis	1. Application form must be completed by a rheumatologist, specialist physician or paedicatrician (in the case of a child). 2. Application form for COXIBs must be accompanied by a motivation for its use over conventional anti-inflammatories. 3. This application form is not applicable for applications for biologics (eg Revellex®, Enbrel®, Humira®, Mabthera®). Call 0860 99 88 77 or visit www.discovery.co.za to request the relevant application form which must be completed by a rheumatologist. Please note that biologics are only covered on Executive and Comprehensive Plans.
Schizophrenia	Application form must be completed by a psychiatrist.
Systemic lupus erythematosus	Application form must be completed by a rheumatologist or nephrologist.
Ulcerative colitis	Application form must be completed by a gastroenterologist.

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3. The Additional Disease List (ADL) conditions covered on Executive and Comprehensive plans
(not covered by the Prescribed Minimum Benefits)

The conditions listed in the table below (as well as the 27 Prescribed Minimum Benefits conditions and HIV/AIDS) are covered only if you are covered on an Executive or Comprehensive Plan. Cover is subject to clinical entry criteria.

ADDITIONAL DISEASE LIST	CLINICAL ENTRY CRITERIA (CEC) REQUIREMENTS
Ankylosing spondylitis	1. Application form must be completed by a rheumatologist. 2. Please provide motivation for applications for COXIBs over conventional non-steroidal anti-inflammatories. *See application process for biologics below.
Behcet's disease	Application form must be completed by a rheumatologist.
Connective tissue disorder (mixed)	Application form must be completed by a rheumatologist.
Cushing's disease	Application form must be completed by an endocrinologist, neurologist or paediatrician (in the case of a child).
Cystic fibrosis	Application form must be completed by a pulmonologist or paediatrician (in the case of a child).
Delusional disorder	Application form must be completed by a psychiatrist.
Dermatopolymyositis	Application form must be completed by a rheumatologist or dermatologist.
Generalised anxiety disorder	Application form 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 psychiatrist or neurologist.
Hypoparathyroidism	Application form must be completed by an endocrinologist.
Major depression	Application form 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.
Organ transplantation	Application form must be completed by a specialist.
Osteoporosis	1. Application form must be accompanied by a DEXA bone mineral density scan (BMD) report. 2. Endocrinologist motivation required in females < 30 years, males and children. 3. Please attach information on additional risk factors in patient, where applicable. 4. Please indicate if the patient sustained an osteoporotic fracture.
Paget's disease	Application form must be completed by a specialist physician or paediatrician (in the case of a child).
Panic disorder	Application form for first line therapy will be accepted from GPs for 6 months only. Psychiatrist motivation is required for further cover.
Paraplegia	None
Pemphigus	Application form must be completed by a dermatologist or paediatrician (in the case of a child).
Peripheral arteriosclerotic disease	Application form must be completed by an appropriate specialist.
Pituitary microadenomas	Application form must be completed by an endocrinologist, neurologist or paediatrician (in the case of a child).
Polyarteritis Nodosa	Application form form must be completed by a rheumatologist.
Post traumatic stress disorder	Application form must be completed by a psychiatrist.
Psoriatic arthritis	1. Application form must be completed by a rheumatologist. 2. *See application process for biologics below.
Pulmonary interstitial fibrosis	Application form must be completed by a pulmonologist or paediatrician (in the case of a child).
Quadriplegia	None
Sjogren's syndrome	Application form must be completed by a rheumatologist.
Stroke	Application form for clopidogrel (Plavix®) must be accompanied by a motivation from a neurologist for use over aspirin therapy.
Systemic sclerosis	Application form must be completed by a rheumatologist.
Thrombocytopaenia purpura	Application form must be completed by a specialist.
Valvular heart disease	Application form must be completed by a cardiologist. Antibiotics are not funded from the Chronic Illness Benefit.
Wegener's granulomatosis	Application form must be completed by a rheumatologist.

*This application form is not applicable for applications for biologics (eg Revellex®, Enbrel®, Humira®). Call 0860 99 88 77 or visit www.discovery.co.za to request the relevant application form which must be completed by a rheumatologist. Please note that biologics are only covered on Executive and Comprehensive Plans.

Patient name and surname Membership number

4. Application for hypertension (to be completed by the doctor)

- This section must be completed for all patients applying for hypertension.
- A specialist must complete this section for patients with hypertension who are younger than 30 years of age. This is in line with the South African Treatment Guidelines for Hypertension.

1. Patient weight in kg Patient height in metres
2. When did this patient commence drug therapy for hypertension? Y Y Y Y M M D D
3. For hypertension **diagnosed in the last six months and all newly diagnosed patients** please supply two initial blood pressure readings (before drug therapy commenced) done at least two weeks apart in order to determine the stage of hypertension.

   i) ______/______ mmHg Date Y Y Y Y M M D D

   ii) ____________ mmHg Date Y Y Y Y M M D D

4. Current BP reading (for all patients) ______/______ mmHg

Does the patient have target organ damage or any of the associated conditions as listed below. Tick relevant conditions below.

Left ventricular hypertrophy ☐	Stroke/TIA ☐	Hypertensive retinopathy ☐
Angina ☐	Chronic renal disease ☐	Prior CABG (Coronary artery bypass graft) ☐
Myocardial infarction ☐	Peripheral arterial disease ☐	Heart failure ☐

5. Application for hyperlipidaemia (to be completed by the doctor)

Primary hyperlipidaemia

Please attach the diagnosing lipogram. The application cannot be reviewed if this is not submitted.

The Chronic Illness Benefit will not fund medicine in patients with less than a 20% risk of a coronary event in the next 10 years. This is in line with the Council for Medical Scheme's Algorithm.

1. Patient weight in kg Patient height in metres
2. Does the patient smoke? Yes ☐ No ☐
3. Family history (Please complete the table below for primary and familial hyperlipidaemia)

	Father	**Mother**	**Brother**	**Sister**
Treatment/event details				
Age at time of diagnosis/event				

4. Current BP reading (for all patients) ______/______ mmHg

Please note: The following questions need to be answered for the application to be processed for primary hyperlipidaemia

Have secondary causes been excluded? Yes ☐ No ☐

Please supply the following results:

a) Hypothyroidism	TSH:
b) Diabetes mellitus	Fasting glucose:
c) Alcohol excess (where applicable)	gamma-GT:
d) Drug induced dyslipidaemia?	Yes ☐ No ☐

Familial hyperlipidaemia

Please attach the diagnosing lipogram. Please complete the family history table above (5.3)

Please indicate any signs of familial hyperlipidaemia in this patient

Secondary prevention

Please indicate what condition/s your patient has:

Type I diabetes with microalbuminuria (please submit supporting clinical reports) ☐

Any of the vasculitides eg SLE where there is associated renal disease ☐

Type II diabetes ☐	Intermittent claudication ☐	Nephrotic syndrome and chronic renal failure ☐
Prior CABG ☐	Stroke/TIA ☐	Ischaemic heart disease ☐

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Patient name and surname | | | | | | | | | | | | | | | | Membership number | | | | | | | | | | | | | |

6. Application for Diabetes type 2

1. Please attach a laboratory report that confirms the diagnosis of type 2 diabetes.
2. The Chronic Illness Benefit will fund medicine for type 2 diabetes if the criteria for the diagnosis of this condition are met based on the SEMDSA Guidelines.
3. The specific criteria are:
   - Fasting plasma glucose concentration ≥ 7.0 mmol/l
   - Random plasma glucose ≥ 11.1 mmol/l
   - Two hour post-glucose ≥ 11.1 mmol/l during an Oral Glucose Tolerance Test (OGTT)
4. Please note that based on cost and clinical guidelines, applications for glitazones and nateglinide require a motivation for use over conventional therapy from a specialist physician or endocrinologist.

7. Current medication required (to be completed by the doctor)

Note to member and doctor: The Chronic Illness Benefit application requirements (ie tests, motivations, supporting documentation or completion by a specialist) are indicated in Section 2 and 3 of this application form. Please read and submit the documentation relevant to the condition you are applying for.

ICD-10	Diagnosis description	Date when condition was first diagnosed	Medicine name, strength and dosage	How long has the patient used this medicine?		May a generic be used	
				Years	Months	Yes	No

8. Doctor's details and signature (to be completed by the doctor)

Name

BHF Practice number

Telephone Work Fax

Email

Speciality ______________________________

Doctor's signature ______________________________ Date Y Y Y Y M M D D

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

Note to doctors:

- **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 from the Medical Savings Account (if applicable to the member's plan type), subject to scheme rules and availability of funds.**
- 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 multiple chronic conditions were applied for, then it would be appropriate to list all the relevant ICD-10 codes.
- You may call 0860 99 88 77 for **changes** to your patient's medication for an **approved** condition. An application form only needs to be completed when applying for a **new chronic condition.**

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