

Please complete this application form as follows:

The Eligible Member must fill in all personal and membership details in Section 1 & 2.

Please ensure that you complete both these sections in full.

The doctor must fill in all medical information required in Section 3 & 4 of the application form.

Please Fax or Email your application to the following:

Fax Number: 086 666 1048

Email: chronic@nbcrflihealth.co.za

SECTION 1: ELIGIBLE MEMBER INFORMATION

Surname:							Initials:															
Title:	Prof	Dr	Mr	Mrs	Miss	Ms	Identity Number:															
Date of Birth:	D	D	M	M	Y	Y	Membership Number:															
Medical Insurance Plan:																						
Employer:																						
Email Address:																						
Tel No. Home:											Tel No. Work:											
Cell:																						

SECTION 2: PATIENT INFORMATION

Surname:							Title:	Prof	Dr	Mr	Mrs	Miss	Ms									
First Names:																						
Date of Birth:	D	D	M	M	Y	Y	Identity Number:															
Tel No. Home:											Tel No. Work:											
Cell:																						
Gender:	M	F											Dependant Code:									
Mass (kg):			Height (cm):			Do you smoke?	Y	N	If yes, how many cigarettes a day?													
How long have you smoked for?			Do you consume alcohol?	Y	N	If yes, state type and quantity:																

If you have any chronic medication queries please contact Customer Care on 0861 00 11 31

Funding from the Chronic Medication Benefit is subject to clinical entry criteria, the medication acquisition rules and formulary determined by Affinity Health and agreed to by the scheme shall apply.

Please Note: Affinity Health adopts a medication reimbursement policy adhering to the single exit pricing structure for all generic and brand name medication. This policy will be implemented at all points of service across all benefits and no exception shall be made, unless prior authorisation has been obtained from Affinity Health.

Should a "non-preferred" medication be required to treat an approved chronic condition, your GP is required to give motivation for this medication via our Medication Appeals Procedure. Medication not pre-authorized as chronic by Affinity Health may not be eligible for reimbursement from the Chronic Medication Benefit.

I hereby give permission for the GP to provide Affinity Health with my diagnosis and other relevant clinical information on this form.

By applying for the Chronic Medication Benefit, I agree that my condition may be subject to disease management interventions.

Signature of Eligible Member

Signature of Patient (Unless a Minor)

Date

SECTION 3: RULES APPLICABLE TO CHRONIC MEDICATION BENEFIT (CMB)

1. All personal and medical details must be submitted accurately by the GP and the patient, where specifically requested.
2. Certain chronic conditions require additional clinical information to be submitted with this application form. Following a Drug Utilisation Review, additional clinical information may also be requested.

Chronic Diagnosis	√	ICD-10 Code	Clinical/Laboratory Supporting Documentation
Cardiac Failure			
Cardiomyopathy			
Coronary Artery Disease			
Dysrhythmias			
Hypertension			BP Reading
Hyperlipidaemia			
Additional Information - Hyperlipidaemia			
Exercise	Y	N	BP Reading
Lipogram Reading (Initial/Diagnostic)			Date of Lipogram: D D M M Y Y
TCL:		LDL:	HDL: Triglycerides:
Risk Factors: (Please indicate where applicable)			
Angina/Myocardial infarction		Angioplasty/Stent	Cerebrovascular Accident (CVA)
Family History		Peripheral Vascular Disease	Transient Ischaemic Attack

Endocrine Diseases:									
Chronic Diagnosis	√	ICD-10 Code	Clinical/Laboratory Supporting Documentation						
Addison's Disease									
Diabetes Insipidus									
Diabetes Mellitus 1									
Diabetes Mellitus 2									
Hypothyroidism									
Additional Information - Diabetes									
Mellitus 1 or 2 Fasting glucose:			Date: D D M M Y Y						
Glucose tolerance test:			Date: D D M M Y Y						

Respiratory Diseases:									
Chronic Diagnosis	√	ICD-10 Code	Clinical/Laboratory Supporting Documentation						
Asthma									
Bronchiectasis									
Chronic Obstructive Pulmonary Disease (COPD)			Stage 1 Stage 2 Stage 3 Initial FEV 1 (spirometry report):						

Autoimmune Diseases:									
Chronic Diagnosis	√	ICD-10 Code	Clinical/Laboratory Supporting Documentation						
Multiple Sclerosis*			*Please note that confirmation of diagnosis by MRI scan is required from a Neurologist. Neurologist Practice Number:						
Systemic Lupus Erythematosus									
Rheumatoid Arthritis*			*Please note that confirmation of diagnosis is required from a Rheumatologist. Rheumatologist Practice Number:						
HIV									

Gastrointestinal Diseases:									
Chronic Diagnosis	√	ICD-10 Code	Clinical/Laboratory Supporting Documentation						
Crohn's Disease									
Ulcerative Colitis									

Neurological Diseases:									
Chronic Diagnosis	√	ICD-10 Code	Clinical/Laboratory Supporting Documentation						
Epilepsy									
Parkinson's Disease									

Ophthalmological Diseases									
Chronic Diagnosis	√	ICD-10 Code	Clinical/Laboratory Supporting Documentation						
Glaucoma									

Other Diseases									
Chronic Diagnosis	√	ICD-10 Code	Clinical/Laboratory Supporting Documentation						
Chronic Renal Disease*			*Glomerular Filtration rate/Creatinine clearance						

1. All Affinity Health rules and exclusions will be applied during the review and authorisation of requested chronic medication in respect of any chronic illness.
2. Only approved General Practitioners within Affinity Health's Provider Network may apply for chronic medication benefits on behalf of Affinity Health members on the contracted Benefit Plans.
3. All approved chronic medication may only be obtained from a dispensary within the Medication Distribution Network authorised by Affinity Health.
4. General Exclusions from Chronic Medication Benefit (C.M.B) include these commonly requested medicines: Exclusions as detailed in the General Practitioner Provider Manual.
5. Access to any medication through the C.M.B is subject to Clinical Entry Criteria and Drug Utilisation Review.
6. Disease marked with * will exclude biological medication.

SECTION 4: CURRENT MEDICATION REQUIRED

Diagnosis:		Medication Name, Strength and Dosage:
Monthly Quantity:	Duration on Medication	Repeats:
	Years: Months:	
Diagnosis:		Medication Name, Strength and Dosage:
Monthly Quantity:	Duration on Medication	Repeats:
	Years: Months:	

MEDICATION HISTORY (IF DIFFERENT FROM CURRENT)

Year	Diagnosis	Medication and Strength	Duration of Use

Patient Allergies:			
State any other illnesses the patient suffers from:			
May current medication be substituted with a generic, if appropriate?			Y N
Are any of the above Diagnoses related to injury on duty?			Y N
If yes, please state:			
Date of Injury:	DD MM YYYY	Injury on Duty (IOD) Number:	

SECTION 5: DOCTOR'S DETAILS

Surname:																	
Practice Postal Address:																	
										Code:							
Practice Physical Address:																	
										Code:							
Tel No:												Fax No:					
Specialty:												Email Address:					
BHF Practice Number:												HPCSA REG No:					
Doctor's Signature:																	
Date: D D M M Y Y																	

