NBCRFLI
Your Road Freight Partner.

Chronic Medication Application Form

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-authorised 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			

Opthalmological 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
Hemophilia			

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			

AFFINITY HEALTH

Affinity Health, a product of National Risk Managers (Pty) Ltd (FSP 47132), the Underwriting Managing Agency; Lion of Africa Life Assurance Company Ltd (FSP 15283), the Insurer. This policy shall be voidable in the event of misrepresentation, misdescription or non-disclosure of any particular material fact to this insurance by or on behalf of an insured person. Terms and conditions as contained in the policy document apply.

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