

# Medicine Management Chronic Medicine Benefit Application



Telephone 0860 100 608

Please fax completed form where possible to: 0800 223 670 | 680

or mail to PO Box 38632, Pinelands, 7430

## A To be completed by the applicant (please print using block letters)

Please book at least 30 minutes with your doctor in order for him/her to examine you and complete this form. The ideal person to do this is the registered practitioner who regularly prescribes your medication. Please keep a copy of the completed form for your records. **Member/patient signature is essential to process this application.**

Should you be accepted onto the Chronic Medicine Management programme, you will be informed in writing. You will receive a medicine "Access Card", which lists the medicine to be paid from the Chronic Medicine Benefit.

### Principal member's details

Member's surname  Title  First name   
 Medical scheme  Membership number   
 Option/Plan

### Patient's details

Patient's surname  Title  First name   
 ID number  Date of birth  Beneficiary code   
 Telephone numbers and code (H) ( ) (W) ( )  
 Fax ( ) Cell   
 Postal address  Code   
 E-mail address

I/we understand that all personal and clinical information supplied to Medscheme Holdings (Pty) Ltd will be kept confidential. Medscheme Holdings (Pty) Ltd will use this information to, inter alia, determine access to the Chronic Medicine Benefit for reimbursement of ongoing essential medication, promote optimal treatment and act in accordance with the rules of the schemes and the provisions of the Medical Schemes Act, Act 131 of 1998 (as amended). Medical staff will review this information in order to make informed recommendations regarding the provision of these benefits. Your medical practitioner, however, retains the ultimate responsibility for his or her patient, irrespective of benefits so authorised.

I/we therefore authorise any healthcare professional, hospital, clinic and/or medical facility in possession of, or may hereafter acquire, any medical information regarding myself, the applicant, and any dependant, whether such information relates to the past or future, to disclose such information to Medscheme Holdings (Pty) Ltd, the Scheme and/or its administrator. I agree that this authorisation and request shall remain in force after my/their deaths. I indemnify the Scheme and its trustees, agents and administrator against any claim, of whatsoever nature, which may be made against them as a result of or arising out of the disclosure of any test results or medical information.

I/we confirm that the information contained in this Chronic Medicine Benefit Application Form is correct.

Member's signature \_\_\_\_\_ Patient's signature \_\_\_\_\_ Date   
 (not required if patient is a minor)

## B To be completed by the attending medical practitioner (please print using block letters)

### Details of the attending medical practitioner

Doctor's surname  Initials  Qualifying degree   
 Practice number  HPCSA Reg. no.   
 Telephone numbers and code ( ) (W) ( )  
 Cell   
 Postal address  Code   
 E-mail address

Please ensure that your patient is applying for the first time as the completion of only one application will be paid for.

### Clinical examination General information (To be completed for all applicants)

Gender   Weight  kg Height  cms Blood pressure (sitting, having rested for 5 minutes)  /  mmHg  
 Smoking   Physical activity    TIA/Stroke    
 Please indicate if the patient has a history of the following: Ischaemic Heart Disease   Peripheral Vascular Disease    
 First degree relative with premature heart disease (Premature = MI in females < 65 years; males < 55 years)    
 If the patient has diabetes, please provide the most recent HbA1c results



