Chronic Illness Benefit application form 2015

This application form is to apply for the Chronic Illness Benefit and is only valid for 2015

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.

How to complete this form

Step 1: Fill in and sign the application form (section 1), and fill in your details on the top of page 4, 5, 6, and 7.
Step 2: Take the application form to your doctor to complete section 2, other relevant sections and sign section 9.
Step 3: Fax the completed application form to 011 539 7000, email it to CIB_APP_FORMS@discovery.co.za or post it to Discovery Health, CIB Department, PO Box 652919, Benmore, 2010.

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. Patient’s details

Name and surname
Date of birth/ID number
Membership number
Telephone
Cellphone
Fax
Email
Outcome of this application must be sent to me by
Email
Fax
Patient’s signature (if patient is a minor, main member to sign)

I acknowledge that I have read and understood the conditions under “Member’s acceptance and permission” on page 2.

2. Doctor’s details

Name and surname
BHF practice number
Speciality
Telephone
Fax
Email
Outcome of this application must be sent to me by
Email
Fax

Contact us
Tel: 0860 99 88 77, PO Box 784262, Sandton, 2146, www.discovery.co.za
Member’s acceptance and permission

I give permission for my healthcare provider 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:
1. Funding from the Chronic Illness Benefit is subject to meeting benefit entry criteria requirements as determined by Discovery Health Medical Scheme and Discovery Health (Pty) Ltd.
2. 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
3. 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.
4. Funding for medicine from the Chronic Illness Benefit will only be effective from when Discovery Health receives an application form that is completed in full.
5. I may need to send an updated or new application form, if the Chronic Illness Benefit department asks for this.
6. Payment for the completion of this form, on submission of a claim, is from the day-to-day benefits (if applicable to the member’s plan type), subject to Scheme rules and availability of funds and where the member is a valid and active member at the service date of the claim.

I consent to Discovery Health Medical Scheme and Discovery Health (Pty) Ltd disclosing, from time to time, information supplied to Discovery Health Medical Scheme and Discovery Health (Pty) Ltd (including general or medical information that is relevant to my application) to my healthcare provider, to administer my Chronic Illness Benefit. I agree that Discovery Health may disclose this information at its discretion, but only as long as all the parties involved have agreed to always keep the information confidential.

### 3. The Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions covered 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 Prescribed Minimum Benefit Chronic Disease List conditions, in line with legislation.

<table>
<thead>
<tr>
<th>Chronic disease list condition</th>
<th>Benefit entry criteria requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addison’s disease</td>
<td>Application form must be completed by a paediatrician (in the case of a child), endocrinologist or specialist physician</td>
</tr>
<tr>
<td>Asthma</td>
<td>None</td>
</tr>
<tr>
<td>Bipolar Mood Disorder</td>
<td>Application form must be completed by a psychiatrist</td>
</tr>
<tr>
<td>Bronchiectasis</td>
<td>Application form must be completed by a paediatrician (in the case of a child), pulmonologist or specialist physician</td>
</tr>
<tr>
<td>Cardiac failure</td>
<td>None</td>
</tr>
<tr>
<td>Cardiomyopathy</td>
<td>None</td>
</tr>
</tbody>
</table>
| 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 |
| Chronic renal disease         | 1. Application form must be completed by a nephrologist or specialist physician  
2. Please attach a diagnosing laboratory report reflecting creatinine clearance |
| Coronary artery disease       | None |
| Crohn’s disease               | Application form must be completed by a gastroenterologist or specialist physician |
| Diabetes insipidus            | Application form must be completed by an endocrinologist |
| Diabetes Type 1               | None |
| Diabetes Type 2               | Section 8 of this application form must be completed by the doctor |
| Dysrhythmias                  | None |
| Epilepsy                      | Application form for newly diagnosed patients 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 HIVCare programme, please call 0860 100 417 |
| Hyperlipidaemia               | Section 6 of this application form must be completed by the doctor |
| Hypertension                  | Section 5 of this application form must be completed by the doctor |
| Hypothyroidism                | Section 7 of this application form must be completed by the doctor |
| Multiple sclerosis (MS)       | 1. Application form must be completed by a neurologist  
2. Please attach a report from a neurologist for applications for beta interferon indicating:  
a. Relapsing – remitting history  
b. All MRI reports  
c. Extended disability status score (EDSS) |
| Parkinson’s disease           | Application form must be completed by a neurologist or specialist physician |
| Rheumatoid arthritis          | Application form must be completed by a rheumatologist, specialist physician, pulmonologist or paediatrician (in the case of a child) |
| Schizophrenia                 | Application form must be completed by a psychiatrist |
| Systemic lupus erythematosus  | Application form must be completed by a rheumatologist, nephrologist, pulmonologist or specialist physician |
| Ulcerative colitis            | Application form must be completed by a gastroenterologist or specialist physician |
4. The Additional Disease List (ADL) conditions covered on Executive and Comprehensive Plans

If you have an Executive or Comprehensive Plan you have cover for all the chronic conditions in the Additional Diseases List below. Your cover is subject to benefit entry criteria.

<table>
<thead>
<tr>
<th>Additional disease list condition</th>
<th>Benefit entry criteria requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ankylosing spondylitis</td>
<td>Application form must be completed by a rheumatologist or specialist physician</td>
</tr>
<tr>
<td>Behcet’s disease</td>
<td>Application form must be completed by a rheumatologist or specialist physician</td>
</tr>
<tr>
<td>Cystic fibrosis</td>
<td>Application form must be completed by a pulmonologist, paediatrician (in the case of a child) or specialist physician</td>
</tr>
<tr>
<td>Delusional disorder*</td>
<td>Application form must be completed by a psychiatrist</td>
</tr>
<tr>
<td>Dermatopolymyositis</td>
<td>Application form must be completed by a rheumatologist or specialist physician</td>
</tr>
<tr>
<td>Generalised anxiety disorder*</td>
<td>Applications for first line therapy will be accepted from GPs for 6 months only. Psychiatrist motivation is required for further cover</td>
</tr>
<tr>
<td>Huntington’s disease</td>
<td>Application form must be completed by a psychiatrist or neurologist</td>
</tr>
</tbody>
</table>
| Isolated growth hormone deficiency in children under 18 years | 1. Application form must be completed by an endocrinologist or paediatrician.  
2. All applications must be accompanied by the relevant laboratory results and growth chart. |
| Major depression*                | Applications 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*               | Application form must be completed by a psychiatrist |
| Obsessive compulsive disorder    | Application form must be completed by a psychiatrist |
| Osteoporosis                     | 1. All applications must be accompanied by a DEXA bone mineral density scan (BMD) Report  
2. Endocrinologist motivation required for patients <50 years  
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                   | Applications for first line therapy will be accepted from GPs for 6 months only. Psychiatrist motivation is required for further cover |
| Polyarteritis nodosa             | Application form must be completed by a rheumatologist |
| Post traumatic stress disorder*  | Application form must be completed by a psychiatrist |
| Psoriatic arthritis              | Application form must be completed by a rheumatologist or specialist physician |
| Pulmonary interstitial fibrosis  | Application form must be completed by a pulmonologist, paediatrician (in the case of a child) or specialist physician |
| Sjögren’s syndrome               | Application form must be completed by a rheumatologist or specialist physician |
| Systemic sclerosis               | Application form must be completed by a rheumatologist or specialist physician |
| Wegener’s granulomatosis         | Application form must be completed by a rheumatologist or specialist physician |

*Although these Diagnostic Treatment Pair Prescribed Minimum Benefit (DTP PMB) conditions are covered on all plan types, the PMB cover does not extend to medicine management. They are included on the Additional Disease List to allow funding for medicines for members on the Executive and Comprehensive plans.

Please note: This application form is not applicable for applications for biologics. Please speak to your specialist to get the relevant form. Biologics are only covered on Executive and Comprehensive Plans.
Patient’s name and surname

Membership number

5. Application for hypertension (to be completed by doctor)

If the patient meets the requirements listed in either A, B or C below, hypertension will be approved for funding from the Chronic Illness Benefit. We may request and review the member’s information retrospectively.

A. Previously diagnosed patients

Was the diagnosis made more than six (6) months ago and has the patient been on treatment for at least that period of time? Yes

B. Please indicate if your patient has any of these conditions

- Chronic renal disease
- Hypertensive retinopathy
- Prior CABG
- Peripheral arterial disease
- Stroke
- TIA
- Angina
- Myocardial infarction
- Pre-eclampsia

C. Newly diagnosed patients

Diagnosis made within the last six (6) months.

Please note: Specialist physician, cardiologist, paediatrician, nephrologist or endocrinologist application is required if the patient is younger than 30 years old, as recommended in the “SA Hypertension Guidelines”.

Blood pressure > 130/85 mmHg and patient has diabetes or congestive cardiac failure or cardiomyopathy

OR

Blood pressure > 160/100 mmHg

OR

Blood pressure > 140/90 mmHg on two or more occasions, despite lifestyle modification for at least 6 months

OR

Blood pressure > 130/85 mmHg and the patient has target organ damage indicated by

- Left ventricular hypertrophy or
- Microalbuminuria or
- Elevated creatinine

We may request and review the member’s information retrospectively.
### 6. Application for hyperlipidaemia (to be completed by doctor)

If the patient meets the requirements listed in either A, B, C or E below, hyperlipidaemia will be approved for funding from the Chronic Illness Benefit. Information provided in section D will be reviewed on an individual basis. We may request and review the member’s information retrospectively.

**A. Primary prevention**

Please attach the diagnosing lipogram, and confirm that the following secondary causes have been excluded and supply the results:

<table>
<thead>
<tr>
<th>Secondary cause</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypothyroidism</td>
<td></td>
</tr>
<tr>
<td>Diabetes Type 2</td>
<td></td>
</tr>
<tr>
<td>Alcohol excess (where applicable)</td>
<td></td>
</tr>
<tr>
<td>Drug-induced hyperlipidaemia</td>
<td>Yes</td>
</tr>
<tr>
<td>Fasting glucose</td>
<td></td>
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<tr>
<td>gamma-GT</td>
<td></td>
</tr>
</tbody>
</table>

Please supply the patient’s current blood pressure reading __________/__________ mmHg.

Is the patient a smoker (defined as any cigarette smoking in the last month or a history of 20 cigarettes a day for 10 years)?

Yes [ ] No [ ]

Please give details of family history of major cardiovascular events:

<table>
<thead>
<tr>
<th></th>
<th>Father</th>
<th>Mother</th>
<th>Brother</th>
<th>Sister</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment or event details</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Age at time of diagnosis or event</td>
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</table>

Please use the Framingham 10-year risk Assessment Chart to determine the absolute 10-year risk of a coronary event (NIH publication no. 01-3670; May 2001)

Does the patient have a risk of 20% or greater

Yes [ ] No [ ]

Is the risk 30% or greater when extrapolated to age 60

Yes [ ]

**B. Familial hyperlipidaemia**

Please attach the diagnosing lipogram

Was the patient diagnosed with homozygous familial hyperlipidaemia and was the diagnosis confirmed by an endocrinologist or lipidologist?

Yes [ ]

OR

Was the patient diagnosed with heterozygous familial hyperlipidaemia and was the diagnosis confirmed by a specialist?

Yes [ ]

Please attach supporting documentation and complete the section below.

Please give details of family history of major cardiovascular events:

<table>
<thead>
<tr>
<th></th>
<th>Father</th>
<th>Mother</th>
<th>Brother</th>
<th>Sister</th>
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<td>Treatment or event details</td>
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<td></td>
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<tr>
<td>Age at time of diagnosis or event</td>
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</tr>
</tbody>
</table>

Please detail signs of familial hyperlipidaemia in this patient:

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**C. Secondary prevention**

Please indicate what condition(s) your patient has:

<table>
<thead>
<tr>
<th>Condition</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Type 2</td>
<td></td>
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<tr>
<td>Intermittent claudication</td>
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<tr>
<td>Prior CABG</td>
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<tr>
<td>Stroke</td>
<td></td>
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<tr>
<td>TIA</td>
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</table>

**Ischaemic heart disease**

**Nephrotic syndrome and chronic renal failure**

**Diabetes Type 1 with microalbuminuria**

**Any vasculitides where there is associated renal disease**

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**D. Please supply any other relevant clinical information about this patient that supports the use of a lipid lowering drug:**

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**E. Was the patient diagnosed with hyperlipidaemia more than five years ago and the laboratory results are not available?**

Yes [ ]
7. Application for hypothyroidism (to be completed by doctor)

If the patient meets the requirements listed in either A, B, C, D or E below, hypothyroidism will be approved for funding from the Chronic Illness Benefit. We may request and review the member’s information retrospectively.

A. Thyroidectomy  
Please indicate whether your patient has had a thyroidectomy
Yes [ ]

B. Radioactive iodine  
Please indicate whether your patient has been treated with radioactive iodine
Yes [ ]

C. Hashimoto’s thyroiditis  
Please indicate whether your patient has been diagnosed with Hashimoto’s thyroiditis
Yes [ ]

D. Please attach the initial or diagnostic laboratory results that confirm the diagnosis of hypothyroidism, including TSH and T4 levels

Was the diagnosis based on the presence of clinical symptoms and one of the following:

A raised TSH and reduced T4 level
Yes [ ]

OR

A raised TSH but normal T4 and higher than normal thyroid antibodies
Yes [ ]

OR

A raised TSH level of greater than or equal to 10 on two or more occasions at least three months apart in a patient with normal T4
Yes [ ]

E. Was the patient diagnosed with hypothyroidism more than five years ago and the laboratory results are not available?  Yes [ ]

8. Application for diabetes type 2 (to be completed by doctor)

If the patient meets the requirements listed in either A, B or C below, diabetes type 2 will be approved for funding from the Chronic Illness Benefit. We may request and review the member’s information retrospectively.

A. Please attach the initial or diagnostic laboratory results that confirm the diagnosis of diabetes type 2

Please note that finger prick and point of care tests are not accepted for registration on the Chronic Illness Benefit.

Do these results show:

A fasting plasma glucose concentration ≥ 7.0 mmol/l
Yes [ ]

OR

A random plasma glucose ≥ 11.1 mmol/l
Yes [ ]

OR

A two hour post-glucose ≥ 11.1 mmol/l during an oral glucose tolerance test (OGTT)
Yes [ ]

OR

An HbA1C (NGSP certified and standardised to DCCT assay) ≥ 6.5% for your patient where you have excluded other factors which influence HbA1C measurements.
Yes [ ]

B. Is the patient a type 2 diabetic on insulin
Yes [ ]

C. Was the patient diagnosed with diabetes type 2 more than five years ago and the laboratory results are not available.  

Important: please note that no exceptions will be made for patients being treated with Metformin monotherapy.  
Yes [ ]
9. Medicine required (to be completed by doctor)

Formulary medicine will be funded to the Discovery Health Medicine rate. There will be no co-payment for medicine selected from the formulary. For non-formulary medicine we fund up to the Chronic Drug Amount (CDA), which is a monthly amount we pay up to, for a specific medicine class. The member may be liable for a co-payment where the cost of the medicine is greater than the CDA (not applicable for KeyCare plans).

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>Diagnosis description</th>
<th>Date when condition was first diagnosed</th>
<th>Medicine name, strength and dosage</th>
<th>How long has the patient used this medicine?</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

Notes to doctors

1. 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 day-to-day benefits (if applicable to the member’s plan type), subject to Scheme rules and availability of funds and where the member is a valid and active member at the service date of the claim.

2. 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 funding for multiple chronic conditions were applied for, then it would be appropriate to list all the relevant ICD-10 codes.

3. We will approve funding for generic medicine, where available, unless you have indicated otherwise.

4. Please submit all the requested supporting documents with this application to prevent delays in the review process.

5. You may call 0860 44 55 66 for changes to your patient’s medicine for an approved condition. An application form only needs to be completed when applying for a new chronic condition.

6. If you have a complex clinical issue that you need to discuss with a doctor or pharmacist, please call 0860 400 600 or email CIB_APP_FORMS@discovery.co.za

[Table for ICD-10 codes and diagnosis descriptions]

Date: [ ]

Doctor’s signature