Chronic Illness Benefit Application form 2020

Discovery Health Medical Scheme

Who we are

Discovery Health Medical Scheme (referred to as 'the Scheme'), registration number 1125, is the medical scheme. This is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the administrator') is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Discovery Health Medical Scheme and takes care of the administration of your membership.

Contact us

Tel (members): 0860 99 88 77, Tel (health partner): 0860 44 55 66, PO Box 784262, Sandton, 2146, www.discovery.co.za, 1 Discovery Place, Sandton, 2196.

Purpose of form

This application form is to apply for the Chronic Illness Benefit and is only valid for 2020. Make reference to the footnote that indicates the expiry date of the form. Download the latest version of all forms from www.discovery.co.za, under Medical Aid > Find a document

How to complete this form

- Fill in the form in black ink and print clearly, or complete the form digitally.
- All relevant sections must be physically signed and cannot be signed digitally. The patient must sign and date any changes.
- Complete and sign section 1.
- Take the application form to your doctor to complete section 2, other relevant sections, sign section 13 and attach any test results, clinical reports or other information that we need to review the request. These requirements are shown in Sections 3 and 4.
- Fax the completed application form and all supporting documents 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.

1. Patient's details

Title | Initials

Surname

First name(s) (as per identity document)

Gender ☐ M ☐ F | Date of birth D D - M M - Y Y Y Y

Membership number

Telephone (H) - | Telephone (W) -

Cellphone - | Fax -

Email

The outcome of this application can be communicated to me by ☐ Email ☐ Fax

I acknowledge that I have read and understood the conditions under "Member's acceptance and permission" on page 2.

Patient's signature (if patient is a minor, main member to sign)

Date D D - M M - Y Y Y Y

⚠ **Please only sign if information is true, complete and correct.**

2. Doctor's details

Name and surname

BHF Practice number

Speciality

Telephone - Fax -

Email

The outcome of this application can be communicated to me by ☐ Email ☐ Fax

Member's acceptance and permission

I give permission for my healthcare provider to provide Discovery Health Medical Scheme and the administrator with my diagnosis and other relevant clinical information required to review my application. I agree to my information being used to develop registries. This means that you give permission for us to collect and record information about your condition and treatment. This data will be analysed, evaluated and used to measure clinical outcomes and make informed funding decisions.

I understand that:

2.1. Funding from the Chronic Illness Benefit is subject to meeting benefit entry criteria requirements as determined by Discovery Health Medical Scheme.

2.2. 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.

2.3. 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.

2.4. Funding for medicine from the Chronic Illness Benefit will only be effective from when Discovery Health Medical Scheme receives an application form that is completed in full. Please refer to the table in Sections 3 and 4 to see what additional information is required to be submitted for the condition for which you are applying.

2.5. An application form needs to be completed when applying for a new chronic condition.

2.6. If you are approved on the benefit, you need to let us know when your treating doctor changes your treatment plan so that we can update your chronic authorisation/s. You can do this by e-mailing the new prescription to us or asking your doctor or pharmacist to do this for you. Alternatively, your doctor can log onto Health ID to make the changes, provided that you have given consent. If you do not let us know about changes to your treatment plan, we may not pay your claims from the correct benefit.

2.7. To make sure that we pay your claims from the correct benefit, we need the claims from your healthcare providers to be submitted with the relevant ICD-10 diagnosis code(s). Please ask your doctor to include your ICD-10 diagnosis code(s) on the claims they submit and on the form that they complete when they refer you to the pathologists and/or radiologists for tests. This will enable the pathologists and radiologists to include the relevant ICD-10 diagnosis code(s) on the claims they submit, ensuring that we pay your claims from the correct benefit.

Consent for processing my personal information

I give the Scheme and the administrator consent to have access to and process all information (including general, personal, medical or clinical information) that is relevant to this application. I understand that this information will be used for the purposes of applying for and assessing my funding request for Chronic Illness Benefits. I consent to the Scheme and the administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical information) to my healthcare provider and to relevant third parties, to administer the Chronic Illness Benefits as well as undertake managed care interventions related to the chronic condition.

3. The Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions covered on all plans

Discovery Health Medical Scheme covers the following Prescribed Minimum Benefit Chronic Disease List conditions in line with legislation. Your cover is subject to benefit entry criteria. Approval on the Chronic Illness Benefit for your PMB CDL condition(s) offers cover for medicine and treatment baskets for the management of your condition(s). Please refer to the website for more information on what is covered on the benefit and how it is covered.

Chronic disease list condition	Benefit entry criteria requirements
Addison's disease	Application form must be completed by an endocrinologist, paediatrician (in the case of a child) or specialist physician
Asthma	None
Bipolar mood disorder	Application form must be completed by a psychiatrist
Bronchiectasis	Application form must be completed by a paediatrician (in the case of a child), pulmonologist or specialist physician
Cardiac failure	None
Cardiomyopathy	None
Chronic obstructive pulmonary disease (COPD)	1. Section 5 of this application form must be completed by the doctor 2. Please attach a lung function test (LFT) report which includes the FEV1/FVC post bronchodilator use 3. Please provide additional information when applying for oxygen including: 3.1. arterial blood gas report off oxygen therapy 3.2. number of hours of oxygen use per day
Chronic renal disease	1. Section 6 of this application form must be completed by the doctor 2. Application form must be completed by a nephrologist or specialist physician 3. Please attach a supporting laboratory report reflecting creatinine clearance
Coronary artery disease	None
Crohn's disease	Application form must be completed by a gastroenterologist, paediatrician (in the case of a child), specialist physician or surgeon
Diabetes insipidus	Application form must be completed by an endocrinologist
Diabetes type 1	None
Diabetes type 2	1. Section 7 of this application form must be completed by the doctor 2. Please attach the diagnosing laboratory report
Dysrhythmia	None
Epilepsy	Application form for newly diagnosed patients must be completed by a neurologist, paediatrician (in the case of a child) or specialist physician
Glaucoma	Application form must be completed by an ophthalmologist
Haemophilia	1. Section 8 of this application form must be completed by the doctor 2. Please attach the diagnosing 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	1. Section 9 of this application form must be completed by the doctor 2. Please attach the diagnosing laboratory report
Hypertension	Section 10 of this application form must be completed by the doctor
Hypothyroidism	1. Section 11 of this application form must be completed by the doctor 2. Please attach the diagnosing laboratory report
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: 2.1. Relapsing – remitting history 2.2. All MRI 2.3. 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, paediatrician (in the case of a child) or specialist physician
Schizophrenia	Application form must be completed by a psychiatrist
Systemic lupus erythematosus	Application form must be completed by a nephrologist, paediatrician (in the case of a child), pulmonologist, rheumatologist or specialist physician
Ulcerative colitis	Application form must be completed by a gastroenterologist, paediatrician (in the case of a child), specialist physician or surgeon

4. The Additional Disease List (ADL) conditions covered on Executive and Comprehensive Plans, except the Classic Smart Comprehensive Plan

If you are on an Executive or Comprehensive Plan, except the Classic Smart Comprehensive Plan you have cover for all the chronic conditions in the Additional Diseases List below. Your cover is subject to benefit entry criteria. Approval on the Chronic Illness Benefit for your ADL condition(s) offers cover for medicine for the management of your condition(s). Please refer to the website for more information on how medicine is covered on the benefit.

Additional disease list condition	Benefit entry criteria requirements
Ankylosing spondylitis	Application form must be completed by a rheumatologist or specialist physician
Behcet's disease	Application form must be completed by a rheumatologist or specialist physician
Cystic fibrosis	Application form must be completed by a paediatrician (in the case of a child), pulmonologist, or specialist physician
Delusional disorder*	Application form must be completed by a psychiatrist
Dermatopolymyositis	Application form must be completed by a dermatologist, rheumatologist or specialist physician
Generalised anxiety disorder*	Applications for first line therapy will be accepted from GPs for 6 months only. Application from a psychiatrist will be required for further cover
Huntington's disease	Application form must be completed by a neurologist or psychiatrist
Isolated growth hormone deficiency in children under 18 years	1. Application form must be completed by an endocrinologist or paediatrician. 2. Please attach the relevant laboratory results and growth chart
Major depression*	Applications for first line therapy will be accepted from GPs for 6 months only. Application from a psychiatrist will be 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
Osteoporosis	1. Section 12 of this application form must be completed by the doctor 2. Application form must be completed by an endocrinologist for patients <50 years of age 3. Please attach the diagnosing DEXA bone mineral density scan (BMD) report
Paget's disease	Application form must be completed by a paediatrician (in the case of a child) or specialist physician
Panic disorder	Applications for first line therapy will be accepted from GPs for 6 months only. Application from a psychiatrist will be 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 paediatrician (in the case of a child), pulmonologist or specialist physician
Sjogren's syndrome	Application form must be completed by a nephrologist, 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 nephrologist, paediatrician (in the case of a child), pulmonologist, 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.

5. Application for chronic obstructive pulmonary disease (to be completed by doctor)

If the patient meets the requirement shown below, chronic obstructive pulmonary disease will be approved for funding from the Chronic Illness Benefit.

Please attach the initial or diagnostic lung function test report which shows an FEV1/FVC post bronchodilator reading of <70%

6. Application for chronic renal disease (to be completed by doctor)

If the patient meets the requirements listed in either A or B below, chronic renal disease will be approved for funding from the Chronic Illness Benefit.

Please tick the ☐ to indicate yes

A. Previously diagnosed patients

☐ The patient has been diagnosed with chronic renal disease and is undergoing dialysis

B. Please attach a laboratory report that shows a creatinine clearance of <60 ml/min

7. 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.

Please tick the ☐ to indicate yes

A. Type 2 diabetic on Insulin

☐ The patient is a type 2 diabetic on insulin

B. 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 **one** of the following:

☐ A fasting plasma glucose concentration ≥ 7.0 mmol/l

☐ A random plasma glucose ≥ 11.1 mmol/l

☐ A 2-hour post-load glucose ≥ 11.1 mmol/l during an oral glucose tolerance test (OGTT)

☐ An HbA1C ≥ 6.5%

C. Initial or diagnostic laboratory test results are not available

☐ The patient was diagnosed with diabetes type 2 more than five years ago and the initial or diagnostic laboratory results are not available

Important: please note that no exceptions will be made for patients being treated with Metformin monotherapy.

8. Application for haemophilia (to be completed by doctor)

If the patient meets either of the requirements listed below, haemophilia will be approved for funding from the Chronic Illness Benefit.

Please tick the ☐ to indicate yes

Please attach the initial or diagnostic laboratory results that confirms the diagnosis of haemophilia

Do the results show **one** of the following:

☐ A factor VIII level of <5%

☐ A factor IX level of <5%

9. Application for hyperlipidaemia (to be completed by doctor)

If the patient meets the requirements listed in either A, B or D below, hyperlipidaemia will be approved for funding from the Chronic Illness Benefit. Information provided in section C will be reviewed on an individual basis.

Please tick the ☐ to indicate yes

A. Primary prevention

Please attach the initial or diagnostic laboratory results that confirms the diagnosis of hyperlipidaemia.

Please use the Framingham 10-year risk Assessment Chart to determine the absolute 10-year risk of a coronary event

(2012 South Africa Dyslipidaemia Guideline) and indicate if the patient:

☐ Has a risk of 20% or greater **or**

☐ Has a risk of 30% or greater when extrapolated to age 60

Please indicate if the patient is:

☐ A smoker or has ever been a smoker

☐ On treatment for Hypertension

Please supply the patient's current blood pressure reading _____ mmHG

Familial hyperlipidaemia

☐ The patient was diagnosed with homozygous or heterozygous familial hyperlipidaemia and the diagnosis was confirmed by an endocrinologist, lipidologist or lipid clinic.

Please attach supporting documentation.

B. Secondary prevention

Please indicate if the patient has/has had a history of **one** of the following:

☐ Diabetes type 2

☐ Stroke

☐ TIA

☐ Coronary artery disease

☐ Any vasculitides where there is associated renal disease (Please attach the supporting laboratory report reflecting creatinine clearance)

☐ Solid organ transplant (Please supply the relevant clinical information in Section C)

☐ Chronic renal disease (Please attach the supporting laboratory report reflecting creatinine clearance)

☐ Peripheral arterial disease (Please attach the doppler ultrasound or angiogram)

☐ Diabetes type 1 with microalbuminuria or proteinuria (Please attach the supporting laboratory report)

C. Please supply any other relevant clinical information about this patient that supports the diagnosis of hyperlipidaemia

D. Initial or diagnostic laboratory test results are not available

☐ The patient was diagnosed with hyperlipidaemia more than five years ago and the initial or diagnostic laboratory results are not available

10. 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

Please tick the ☐ to indicate yes

A. Previously diagnosed patients

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

B. Please indicate if the patient has/has had a history of one of the following:

☐ Chronic renal disease

☐ Stroke

☐ Peripheral arterial disease

☐ Myocardial infarction

☐ Coronary artery disease

☐ Prior CABG

☐ Hypertensive retinopathy

☐ Pre-eclampsia

☐ TIA

C. Newly diagnosed patients

The diagnosis was made within the last six (6) months and the patient has a:

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

☐ Blood pressure ≥ 160/100 mmHg

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

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

- Left ventricular hypertrophy or
- Microalbuminuria or
- Elevated creatinine

11. Application for hypothyroidism (to be completed by doctor)

If the patient meets the requirements listed in either A, B or C below, hypothyroidism will be approved for funding from the Chronic Illness Benefit.

Please tick the ☐ to indicate yes

A. Please specify the relevant clinical information. The patient:

☐ Has had a Thyroidectomy

☐ Has been treated with Radioactive iodine

☐ Has been diagnosed with Hashimoto's Thyroiditis

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

Do these results show:

☐ A raised TSH and reduced T4 level

☐ A raised TSH but normal T4 level and higher than normal thyroid antibodies

☐ A raised TSH level of greater than 10 mIU/l on two or more occasions at least three months apart in a patient with normal T4 levels

C. Initial or diagnostic laboratory test results are not available

☐ The patient was diagnosed with hypothyroidism more than five years ago and the initial or diagnostic laboratory results are not available

12. Application for osteoporosis (to be completed by doctor)

If the patient meets the requirements listed in either A, B or C below, osteoporosis will be approved for funding from the Chronic Illness Benefit.

Please tick the ☐ to indicate yes

A. Osteoporotic fracture

☐ The patient has been diagnosed with an osteoporotic fracture of the spine, forearm, hip or shoulder

B. Spinal wedging

☐ The patient has 1 spinal wedge. Please attach the diagnosing DEXA bone mass density scan results.

☐ The patient has 2 or more spinal wedges.

C. Please attach the diagnosing DEXA bone mass density scan results that confirm the diagnosis of osteoporosis

Do these results show:

☐ T-score of the AP Spine is ≤ -2.5

☐ T-score of the right hip is ≤ -2.5

☐ T-score of the left hip is ≤ -2.5

☐ T-score of the right femoral hip is ≤ -2.5

☐ T-score of the left femoral hip is ≤ -2.5

13. Medicine required (to be completed by doctor)

To assist us in paying claims for the diagnosis of condition(s) from the correct benefits, please ensure that you include the **date when the condition was first diagnosed** in the table below.

ICD-10 code	Condition description	Date when condition was first diagnosed	Medicine name, strength and dosage	How long has the patient used this medicine?	
				Years	Months

Notes to doctors

13.1. Please ensure that the relevant ICD-10 diagnosis code(s) are used when you submit your claims to the Scheme to ensure payment from the correct benefit.

13.2. Please include the ICD-10 diagnosis code(s) when referring your patient to the pathologists and/or radiologists. This will enable the pathologists and radiologists to include this information on their claims and allow us to comply with legislation by paying Prescribed Minimum Benefits (PMB) claims correctly.

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

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

13.5. Should you make changes to your patient's treatment plan, you need to let us know so that we can update their chronic authorisation/s. You can do this by e-mailing the new prescription to us or by logging onto Health ID to make the changes, provided that the patient has given consent. If you or your patient do not let us know about changes to the treatment plan, we may not pay claims from the correct benefit.

Signature of doctor

Date D D - M M - Y Y Y Y

Please only sign if information is true, complete and correct.