PLATINUM HEALTH

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PLATCOMPREHENSIVE CHRONIC ILLNESS BENEFIT APPLICATION FORM

1. Please complete the chronic illness benefit application form in PRINT with black ink and forward to Platinum Health.
2. Relevant test results must be attached.
3. Prescription must be attached.
4. Failure to provide all information, will result in unnecessary delays.

1 PATIENT INFORMATION (Please complete in full)

Platinum Health membership number: | | | | | | | | | | | Patient dependant code: | |

Title: Prof | Dr | Mr | Ms Initials: | Surname: |

Names in full (as per identity document): |

Date of birth: C C Y Y M M D D E-mail: |

Tel no (Home): | Tel no (Work): | Cell no: |

Sex: Male | Female Language preference: English | Afrikaans

The outcome of this application must be communicated to me via Email | SMS

2 DECLARATION

I hereby apply for PLATINUM HEALTH CHRONIC ILLNESS BENEFIT and agree that I will be bound by the Rules of the Scheme as amended from time to time.

I warrant that the information in this application, whether it is in my own handwriting or not, is complete and correct. This also applies to information in other documents provided by the healthcare provider, healthcare facility, any of my dependants or myself.

Principal member signature: |

Patient signature: | (If the patient is a minor, parent, legal guardian or custodian must sign the form.)

Date: C C Y Y M M D D

Please complete and fax to 086 577 0274

Platinum Health membership number:

Patient name and surname:

3 APPLICATION FOR THE TREATMENT OF HYPERTENSION (to be completed by the doctor)

Patient weight in kilogram: Patient height in metres:

When did this patient commence drug therapy for hypertension? C C Y Y M M D D

For hypertension diagnosed in the last six months and all newly diagnosed patients please supply two initial blood pressure readings (before drug therapy commenced) done at least two weeks apart in order to determine the stage of hypertension.

1. ..... / ..... mmHg Date: C C Y Y M M D D

2. ..... / ..... mmHg Date: C C Y Y M M D D

Current BP reading (for all patients): ..... / ..... mmHg

Does the patient have target organ damage or any of the associated conditions as listed below? Tick the relevant conditions below.

- Left ventricular hypertrophy
- Myocardial infarction
- Hypertensive retinopathy
- Angina
- Chronic renal disease
- Prior CABG (Coronary artery bypass graft)
- Stroke TIA
- Peripheral arterial disease
- Heart failure

4 APPLICATION FOR THE TREATMENT OF HYPERLIPIDAEMIA (to be completed by the doctor)

Primary Hyperlipidaemia

Please attach the diagnostic lipogram and current TSH. The application cannot be reviewed if this is not submitted.

Patient weight in kilogram: Patient height in metres:

Current BP reading (for all patients): ..... / ..... mmHg

Does the patient smoke: Yes No

Family history (Please complete the table below for primary and familial hyperlipidaemia)

	FATHER	MOTHER	BROTHER	SISTER
Event description				
Age at time of event/death				

Familial hyperlipidaemia

Please attach the diagnosing lipogram. Please indicate any signs of familial hyperlipidaemia in these patients:

- Xanthelasma
- Cerebrotendinous xanthomastosis
- Arcus Cornealis

Secondary prevention

Please indicate the condition(s) your patient has:

- Type 2 diabetes
- Type 1 diabetes who has had the condition for more than 10 years
- Any of the vasculitides eg SLE where there is associated renal disease
- Nephrotic syndrome and chronic renal failure
- Stroke TIA
- Prior CABG
- Ischaemic heart disease
- Intermittent claudication

Please complete and fax to 086 577 0274

Platinum Health membership number:

Patient name and surname:

5 APPLICATION FOR THE TREATMENT OF TYPE 2 DIABETES

1. Please attach a laboratory report that confirms the diagnosis of Type 2 Diabetes .

2. The Chronic Illness Benefit will fund medication for Type 2 Diabetes if the criteria for the diagnosis of this condition are met based on the SEMDSA Guidelines.

3. The specific criteria are:
   - Fasting plasma glucose concentration > 7 mmol/l;
   - Casual plasma glucose concentration > 11.1 mmol/l; and
   - Two hour post-glucose or > 11.1 mmol/l during an Oral Glucose Tolerance Test (OGTT).

4. Please note that based on cost and clinical guidelines, applications for glitazones, nateglinide, GLP-1 agonists, and DPP-4 antagonists require a motivation for use over conventional therapy from a specialist physician or endocrinologist.

6 CURRENT MEDICATION REQUIRED (to be completed by the doctor)

NOTE TO MEMBER AND DOCTOR: GENERIC SUBSTITUTION WILL BE APPLIED, PLATINUM HEALTH WILL APPLY MMAP. PLATINUM HEALTH HAS ADOPTED A REFERENCE PRICING PROGRAMME, WHERE THE PATIENT NOTWITHSTANDING ELECTS TO TAKE A HIGHER PRICED PRODUCT PRESCRIBED THE PATIENT IS LIABLE FOR THE DIFFERENCE IN THE CALCULATED GROSS PRICES FOR THE RESPECTIVE PRODUCTS.

ICD-10	DESCRIPTION OF DIAGNOSIS	DATE OF FIRST DIAGNOSIS	MEDICATION NAME, STRENGTH AND DOSAGE	HOW LONG HAS THE PATIENT USED THIS MEDICATION?		MAY A GENERIC BE USED?	
				YEARS	MONTHS	YES	NO

7 DOCTOR'S DETAILS AND SIGNATURE (to be completed by the doctor)

NOTE TO DOCTOR: THE DOCTOR'S FEE FOR COMPLETION OF THIS FORM WILL BE REIMBURSED ON CODE 0199, ON SUBMISSION OF A SEPARATE CLAIM. SUBJECT TO SCHEME RULES AND AVAILABILITY OF FUNDS. IN LINE WITH LEGISLATIVE REQUIREMENTS, PLEASE ENSUR E 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 MULTIPLE CHRONIC CONDITIONS WERE APPLIED FOR, THEN IT WOULD BE APPROPRIATE TO LIST ALL THE RELEVANT ICD-10 CODES. YOU MAY CALL 014 590 1700 (OPTION 4) FOR CHANGES TO YOUR PATIENT'S MEDICATION FOR AN APPROVED CONDITION. AN APPLICATION FORM ONLY NEEDS TO BE COMPLETED WHEN APPLYING FOR A NEW CHRONIC CONDITION.

Name: BHF practice number:

Date: C C Y Y M M D D Speciality:

Tel no (Practice): Doctor's signature:

Please complete and fax to 086 577 0274

Platinum Health membership number:

Patient name and surname:

PRESCRIBED MINIMUM BENEFITS (PMBs)

ADDISON'S DISEASE: Application form must be completed by a paediatrician or endocrinologist.

ASTHMA: The South African Treatment Guidelines for Asthma, as published in the SAMJ are applied to all applications.

BIPOLAR MOOD: Disorder Application form must be completed by a psychiatrist.

BRONCHIECTASIS: Application form must be completed by a paediatrician or pulmonologist.

CARDIAC FAILURE: None

CARDIOMYOPATHY: None

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD): Please attach a lung function test (LFT) report which includes the FEV1/FVC and FEV1 post bronchodilator use.

CHRONIC RENAL DISEASE: 1. Please attach proof of diagnosis completed by a nephrologist. 2. Please attach a diagnosing laboratory report reflecting creatinine clearance. 3. Please attach a report reflecting haemoglobin or haematocrit levels when applying for erythropoietin, indicating if the results are on or off drug therapy.

CORONARY ARTERY DISEASE: Please provide details of previous cardiovascular event(s) in patient, if applicable.

CROHN'S DISEASE: Please attach proof of diagnosis completed by a gastroenterologist.

DIABETES INSIPIDUS: Please attach proof of diagnosis completed by an endocrinologist.

DIABETES TYPE 1: None

DIABETES TYPE 2: Refer to Section 5.

DYSRHYTHMIAS: None

EPILEPSY: None

GLAUCOMA: None

HAEMOPHILIA: Please attach a laboratory report reflecting factor 8 or 9 levels.

HIV/AIDS (ANTIRETROVIRAL THERAPY): Documented proof that patient qualified for ART treatment in accordance with National Antiretroviral Treatment guidelines.

HYPERLIPIDAEMIA: Section 4 must be completed by the doctor.

HYPERTENSION: Section 3 must be completed by the doctor.

HYPOTHYROIDISM: Please attach the initial or diagnostic laboratory report that confirms the diagnosis of hypothyroidism, including TSH, T4 and T3 levels.

MULTIPLE SCLEROSIS (MS): Please attach proof of diagnosis completed by a neurologist.

PARKINSON'S DISEASE: Only applications from a neurologist for non-formulary items will be considered.

RHEUMATOID ARTHIRITIS: 1. Please attach proof of diagnosis completed by a rheumatologist. 2. Applications for anti-inflammatories as monotherapy (on its own) must be motivated for by a rheumatologist. 3. Applications for COXIB's must be accompanied by a motivation for its use over conventional anti-inflammatories. 4. Only applications from a rheumatologist for non-formulary items will be considered.

SCHIZOPHRENIA: Application must be completed by a psychiatrist.

SYSTEMIC LUPUS ERYTHEMATOSUS: Application must be completed by a rheumatologist, nephrologist or physician.

ULCERATIVE COLITIS: Please attach proof of diagnosis completed by a gastroenterologist.

OTHER CHRONIC DISEASES

ACNE: Only applications from a dermatologist for isotretinoin will be considered.

ALLERGY MANAGEMENT (CONJUNCTIVITIS AND KERATOCONJUCTIVITIS, VASOMOTOR AND ALLERGIC RHINITIS, ATONIC DERMITITIS AND URTICARIA): None

ALZHEIMER'S DISEASE: Please attach proof of diagnosis by a psychiatrist or neurologist.

ANAEMIA (CHRONIC): 1. Attach proof of specific anaemia. 2. Request for iv treatmentto be accompanied by relevant blood results.

ANKYLOSING SPONDYLITIS: 1. Please attach proof of diagnosis by a rheumatologist. 2. Application for COXIBS must be accompanied by a motivation for its use over conventional anti-inflammatories. 3. Only applications from a rheumatologist for non-formulary items will be considered.

ANXIETY DISORDER (CHRONIC): 1. Application for firstline therapy will be accepted from GP's for six months only. 2. Psychiatrist motivation required for further cover.

ATTENTION DEFICIT DISORDER (ADD): 1. Full psychometric evaluation required. 2. Diagnosis by psychiatrist.

BENIGN PROSTATIC HYPERTROPHY: None

CEREBRAL PALSY: Please attach proof of diagnosis by a neurologist.

CEREBROVASCULAR ACCIDENT (STROKE): None

CHRONIC BRONCHITIS: None

CHRONIC LIVER DISEASE: Please attach proof of diagnosis by a gastroentorologist. Immune modulators will only be considered by a specialist.

CLOTTING DISORDERS: None

CYSTIC FIBROSIS: Please attach proof of diagnosis by a pulmonologist (or paediatrician if the patient is a child).

DEEP VEIN THROMBOSIS: None

DEPRESSION: 1. Application for firstline therapy will be accepted from GP's for six months only. 2. Psychiatrist motivation required for further cover.

DYSRYTHMIA (NON PMB): None

ENDOCARDITIS: None

GASTRO-OESOPHAGEAL REFLUX DISEASE AND DIAPHRAGMATIC HERNIA: Applications must be accompanied by latest gastroscopy report.

GOUT (CHRONIC): None. Colchinine will not be considered for chronic treatment.

IRRITABLE BOWEL SYNDROME / DIVERTICULITIS: None

MENIERE'S DISEASE: None

MENOPAUSE: Application for hormone replacement therapy will only be considered up to the age of 60 years. Exceptions must be motivated by a gynaecologist.

MIGRAINE: Only firstline therapy will be considered from GP's, otherwise application from neurologist.

MOTOR NEURON DISEASE: None

MUSCULAR DYSTROPHY AND OTHER INHERITED MYOPATHIES: None

NARCOLEPSY: Please attach proof of diagnosis by a neurologist.

NEUROPATHY: None

OBSESSIVE COMPULSIVE DISORDER: Application for firstline therapy will be accepted from GP's for six months only. Psychiatrist motivation required for further cover.

OSTEOARTHRITIS: X-ray report.

OSTEOPOROSIS: Application must be accompanied by a DEXA bone mineral density (BMD) scan report.

PAGET'S DISEASE: Please attach proof of diagnosis by a specialist physician or paediatrician (in case of a child).

PANCREATIC DISEASE: Please attach proof of diagnosis by a endocrinologist.

PLEGIA: HEMI, PARA, QUAD: None

PARATHYROID DISORDERS: Please attach proof of diagnosis by a endocrinologist or physician.

PEPTIC ULCER: Application must be accompanied by latest gastroscopy report.

PERIPHERAL VASCULAR DISEASE: None

PITUITARY GLAND DISORDERS: Please attach proof of diagnosis by a endocrinologist.

POLYCISTIC OVARIAN SYNDROME: Please attach proof of diagnosis by appropriate specialist.

POST TRAUMATIC STRESS DISORDER: Application for firstline therapy will be accepted from GP's for six months only. Psychiatrist motivation required for further cover.

PROLACTINOMA: Please attach proof of diagnosis by a endocrinologist or physician.

PSORIASIS: None

PULMONARY INTERSTITIAL FIBROSIS: None

RESTLESS LEGS SYNDROME: None

SCHIZOAFFECTIVE DISORDERS: Please attach proof of diagnosis by a psychiatrist.

SCLERODERMA: Please attach proof of diagnosis by appropriate specialist.

TOURETTE'S SYNDROME: Please attach proof of diagnosis by a neurologist.

TRIGEMINAL NEURALGIA: Please attach proof of diagnosis by a neurologist.

TUBERCULOSIS: Please attach proof that patient qualifies for treatment according to national guidelines.

URINARY INCONTINENCE: Application for non-formulary items will only be considered from a urologist.

VALVULAR HEART DISEASE: Please attach proof of diagnosis by a cardiologist/physician.

VASCULAR DEMENTIA: Please attach proof of diagnosis by a neurologist.

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