NASPERS Mediese FONDS Medical FUND

N Option Plus • N Option Basic

Administered by Discovery Health

Contact details

Tel: 0860 627 633, PO Box 652509, Benmore 2010, www.nasmed.com

Chronic Illness Benefit application form 2014

This application form is to apply for the Chronic Illness Benefit and is only valid for 2014

The latest version of the application form is available on www.nasmed.com. Alternatively members can phone 0860 627 633 and health professionals can phone 0860 44 55 66.

What you must do

Please go through these steps:

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 Naspers Medical Fund, 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 or ID number

Membership number

Telephone

Fax

Cellphone

Email

Outcome of this application must be sent to me by: Email ☐ Fax ☐

Patient's signature

(if patient is a minor, main member/legal guardian to sign)

Date Y Y Y Y M M D D

I acknowledge that I have read and understood the conditions under "Notes to member" on page 2.

2. Doctor's details

Name and surname

BHF practice number

Specialty

Telephone

Fax

Email

Outcome of this application must be sent to me by: Email ☐ Fax ☐

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Notes to member

I give permission for my healthcare provider to provide Naspers Medical Fund and Discovery Health (Pty) Ltd 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 Naspers Medical Fund.
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 Naspers Medical Fund 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.

I consent to Naspers Medical Fund and Discovery Health (Pty) Ltd disclosing, from time to time, information supplied to Naspers Medical Fund 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 Naspers Medical Fund and Discovery Health (Pty) Ltd 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 N Option Plus and N Option Basic plans

For information only. Do not fax this page to Naspers Medical Fund. Naspers Medical Fund covers the following Prescribed Minimum Benefit Chronic Disease List conditions in line with legislation.

Chronic disease list condition	Benefit entry criteria requirements
Addison's disease	Application form must be completed by a paediatrician (in the case of a child), endocrinologist 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. 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 HIV*Care* 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 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 or specialist physician
Ulcerative colitis	Application form must be completed by a gastroenterologist or specialist physician

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4. The Additional Disease List (ADL) conditions covered on N Option Plus plan

Your cover is subject to benefit entry criteria.

Additional disease list condition	Benefit entry criteria requirements
Alzheimer's Disease	Application form must be completed by a psychiatrist, neurologist or specialist physician
Attention deficit hyperactivity disorder	Application form must be completed by a psychiatrist, neurologist or paediatrician (in the case of a child). Only applications for children < 18 years of age will be considered
Chronic backache	None
Corneal transplant	Application form must be completed by an ophthalmologist or surgeon
Cystic fibrosis	Application form must be completed by a pulmonologist, paediatrician (in the case of a child) or specialist physician
Depression	Application form must be completed by a psychiatrist
Gastro-oesophageal reflux disease	Application form must be completed by a gastroenterologist, general surgeon or paediatrician (in the case of a child)
Gout	None
Osteoporosis	1. All applications must be accompanied by a DEXA bone mineral density scan (BMD) Report 2. Endocrinologist motivation required for patients younger than 50 years 3. Please attach information on additional risk factors in patient, where applicable 4. Please indicate if the patient sustained an osteoporotic fracture
Psoriasis	None

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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.

Please note: *For patients with refractory hypertension who require more than three classes of medicines, the application should be completed by a specialist physician, cardiologist, paediatrician, nephrologist or endocrinologist.*

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

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 Yes ☐

OR

Blood pressure ≥ 160/100 mmHg Yes ☐

OR

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

OR

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

- Left ventricular hypertrophy or
- Microalbuminuria or
- Elevated creatinine

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Patient's name and surname

Membership number

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

If the patient meets the requirements listed in either A, B or C 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:

Hypothyroidism	TSH:	
Diabetes type 2	Fasting glucose:	
Alcohol excess (where applicable)	Gamma-GT:	
Drug-induced hyperlipidaemia	Yes ☐	No ☐

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:

	Father	Mother	Brother	Sister
Treatment or event details				
Age at time of diagnosis or event				

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 ☐

OR

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

B. Familial hyperlipidaemia

Please attach the diagnosing lipogram

Patient has had diagnosis of homozygous familial hyperlipidaemia confirmed by an endocrinologist or lipidologist. Please attach supporting documentation. Yes ☐

OR

Patient has had diagnosis of heterozygous familial hyperlipidaemia confirmed by a specialist. Please attach supporting documentation and complete the section below. Yes ☐

Please give details of family history of major cardiovascular events:

	Father	Mother	Brother	Sister
Treatment or event details				
Age at time of diagnosis or event				

Please detail signs of familial hyperlipidaemia in this patient:

_____

_____

C. Secondary prevention

Please indicate what conditions your patient has:

Diabetes type 2	☐	Ischaemic heart disease	☐
Intermittent claudication	☐	Nephrotic syndrome and chronic renal failure	☐
Prior CABG	☐	Diabetes type 1 with microalbuminuria	☐
Stroke	☐	Any vasculitides where there is associated renal disease	☐
TIA	☐		

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

_____

_____

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Patient's name and surname

Membership number

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

If the patient meets the requirements listed in either A, B, C or D 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 and clinical symptoms Yes ☐

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

If the patient meets the requirements listed in either A or B 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 $\geq$ 7.0 mmol/l? Yes ☐

OR

A random plasma glucose $\geq$ 11.1 mmol/l? Yes ☐

OR

A two hour post-glucose $\geq$ 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 ☐

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Patient's name and surname

Membership number

9. Medicine required (to be completed by doctor)

Formulary medicine will be funded up to the Fund Rate for Medicine.

ICD-10	Diagnosis 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

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 codes. As per industry standards, the appropriate ICD-10 codes to use for this purpose would be those reflective of the actual chronic conditions for which the form was completed. If funding for multiple chronic conditons 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 cover 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

Doctor's signature

Date Y Y Y Y M M D D

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