Maxima

Real medical aid, pure and simple

APPLICATION FOR MEMBERSHIP

FEDHEALTH

Please complete in BLACK ink
Print clearly using CAPITAL letters
Only one character per block
Leave one block between words
Mark with an ☒ where necessary

FEDHEALTH MEDICAL SCHEME
Call Centre 0860 002 153

SECTION 1 CHOICE OF OPTION AND SAVINGS LEVEL

Choose ONE product and ONE savings level option by placing an "x" in the appropriate box

OPTION SELECTION

☐ MAXIMA PLUS
including out of hospital expenses benefit with savings as selected below

☐ MAXIMA STANDARD
including out of hospital expenses benefit with savings as selected below

☐ MAXIMA CORE
no out of hospital expenses benefit with savings as selected below

SAVINGS SELECTION ☐ 0% ☐ 5% ☐ 10% ☐ 15% ☐ 20% ☐ 25%

I wish to join the scheme from 0 1 m m 2 0 y y

Membership number (administrative use only)

SECTION 2 INTERMEDIARY

This section must be signed by the broker / agent

Broker code

FSB licence number

Name of brokerage / broker / agent

Telephone number (W) c o d e

Cell

Fax number c o d e

E-mail address

Broker's / agent's signature .....

Date d d m m y y y y

Name of broker consultant *if applicable*

SECTION 3 DETAILS OF PRINCIPAL MEMBER

Please leave a block between names

Surname

Title

First name/s

Initials

Gender M F

Date of birth d d m m y y y y

ID/passport number

Telephone (H) c o d e

Telephone (W) c o d e

Cellular

Fax c o d e

E-mail address

Postal address

Postal code

Physical address

Postal code

Are you changing your medical scheme due to a change in your employment? Yes No

Have you had previous medical aid cover? Yes No *If yes, please provide details below.*

Have condition specific waiting periods, exclusions or late joiner penalties ever been imposed on you when applying for membership of any other medical scheme/s? Yes No

Name of previous medical scheme	Membership number	Date joined	Date left

PLEASE ☒ - *FOR STATISTICAL PURPOSES ONLY* Ethnic group Black Coloured Indian White Asian

Marital status Single Married Divorced Widowed Common law partner/spouse

SECTION 4 DEPENDANTS YOU WISH TO REGISTER

Number of dependants to be registered *(include spouse, child and adult dependants)*

1 SPOUSE

Title | Initials | First name/s

Surname

Relationship to principal member | Gender M F

ID/passport/birth certificate number | Date of birth d d m m y y y y

Has this dependant had previous medical aid cover? Yes No *If yes, please provide details below.*

Have condition specific waiting periods, exclusions or late joiner penalties ever been imposed on this dependant on application for membership of any other medical scheme/s? Yes No

Name of previous medical scheme	Membership number	Date joined	Date left

2

Adult | Child *Adult dependant = 27 years of age or older*

Title | Initials | First name/s

Surname

Relationship to principal member | Gender M F

ID/passport/birth certificate number | Date of birth d d m m y y y y

If *adult*, is the dependant financially dependent on the principal member? Yes No

Does the dependant receive an income, e.g. pension, salary? Yes No | If yes, what is the monthly income? R

Has this dependant had previous medical aid cover? Yes No *If yes, please provide details below.*

Have condition specific waiting periods, exclusions or late joiner penalties ever been imposed on this dependant on application for membership of any other medical scheme/s? Yes No

Name of previous medical scheme	Membership number	Date joined	Date left

3

Adult | Child *Adult dependant = 27 years of age or older*

Title | Initials | First name/s

Surname

Relationship to principal member | Gender M F

ID/passport/birth certificate number | Date of birth d d m m y y y y

If *adult*, is the dependant financially dependent on the principal member? Yes No

Does the dependant receive an income, e.g. pension, salary? Yes No | If yes, what is the monthly income? R

Has this dependant had previous medical aid cover? Yes No *If yes, please provide details below.*

Have condition specific waiting periods, exclusions or late joiner penalties ever been imposed on this dependant on application for membership of any other medical scheme/s? Yes No

Name of previous medical scheme	Membership number	Date joined	Date left

SECTION 4 DEPENDANTS YOU WISH TO REGISTER *Continued*

4 Adult ☐ Child ☐ *Adult dependant = 27 years of age or older*

Title | Initials | First name/s

Surname

Relationship to principal member | Gender M F

ID/passport/birth certificate number | Date of birth d d m m y y y y

If *adult*, is the dependant financially dependent on the principal member? Yes No

Does the dependant receive an income, e.g. pension, salary? Yes No If yes, what is the monthly income? R

Has this dependant had previous medical aid cover? Yes No *If yes, please provide details below.*

Have condition specific waiting periods, exclusions or late joiner penalties ever been imposed on this dependant on application for membership of any other medical scheme/s? Yes No

Name of previous medical scheme	Membership number	Date joined	Date left

5 Adult ☐ Child ☐ *Adult dependant = 27 years of age or older*

Title | Initials | First name/s

Surname

Relationship to principal member | Gender M F

ID/passport/birth certificate number | Date of birth d d m m y y y y

If *adult*, is the dependant financially dependent on the principal member? Yes No

Does the dependant receive an income, e.g. pension, salary? Yes No If yes, what is the monthly income? R

Has this dependant had previous medical aid cover? Yes No *If yes, please provide details below.*

Have condition specific waiting periods, exclusions or late joiner penalties ever been imposed on this dependant on application for membership of any other medical scheme/s? Yes No

Name of previous medical scheme	Membership number	Date joined	Date left

SECTION 5 MEDICAL DETAILS

It is compulsory to answer each question. Failure to disclose information is fraud and may result in membership not being granted, termination of membership without refund of contributions paid.

Current family doctor

Name and surname

Telephone c o d e | How long has he/she been your doctor?

HAVE YOU OR ANY OF YOUR DEPENDANTS SOUGHT ANY ADVICE, BEEN DIAGNOSED WITH, OR TREATED FOR, ANY OF THE FOLLOWING CONDITIONS IN THE PAST 12 MONTHS?

1. **Heart and circulation** Do you or any of your dependants suffer from any pulmonary or circulatory problems such as high or low blood pressure, etc? If yes, provide details. Yes No

Name of beneficiary	Diagnosis and date	Name of medication	Are you currently receiving treatment?		Have you been hospitalised?		Name and contact number of treating GP, Dentist or Specialist
			Yes	No	Yes	No	
			Yes	No	Yes	No	

2. **Breathing or respiratory** Do you or any of your dependants have any disorders associated with breathing or respiration such as asthma etc? If yes, provide details. Yes No

Name of beneficiary	Diagnosis and date	Name of medication	Are you currently receiving treatment?		Have you been hospitalised?		Name and contact number of treating GP, Dentist or Specialist
			Yes	No	Yes	No	
			Yes	No	Yes	No	

3. **Bladder and kidneys** Do you or any of your dependants suffer from urinary disorders? (e.g. kidney stones) If yes, provide details. Yes No

Name of beneficiary	Diagnosis and date	Name of medication	Are you currently receiving treatment?		Have you been hospitalised?		Name and contact number of treating GP, Dentist or Specialist
			Yes	No	Yes	No	
			Yes	No	Yes	No	

4. **Reproductive organs** Do you or any of your dependants suffer from any reproductive disorder? (e.g. prostate disorder, endometriosis, ovarian cysts, menstrual disorders)
If yes, provide details. Yes No

Name of beneficiary	Diagnosis and date	Name of medication	Are you currently receiving treatment?		Have you been hospitalised?		Name and contact number of treating GP, Dentist or Specialist
			Yes	No	Yes	No	
			Yes	No	Yes	No	

5. **Digestive system** Do you or any of your dependants suffer from any gastro intestinal disorders? (e.g. gastro-oesophageal reflux disease, heartburn, stomach or duodenal disorders, Crohn's disease, ulcerative colitis, diverticulitis and/or spastic colon) If yes, provide details. Yes No

Name of beneficiary	Diagnosis and date	Name of medication	Are you currently receiving treatment?		Have you been hospitalised?		Name and contact number of treating GP, Dentist or Specialist
			Yes	No	Yes	No	
			Yes	No	Yes	No	

6. **Ear, nose and throat disorders** such as deafness, ear infections, harelip, cleft palate or any other nose, ear or throat problems?
If yes, provide details. Yes No

Name of beneficiary	Diagnosis and date	Name of medication	Are you currently receiving treatment?		Have you been hospitalised?		Name and contact number of treating GP, Dentist or Specialist
			Yes	No	Yes	No	
			Yes	No	Yes	No	

7. **Eyes** (e.g. Glaucoma, cataracts, visual disorders) If yes, provide details. Yes No

Name of beneficiary	Diagnosis and date	Name of medication	Are you currently receiving treatment?		Have you been hospitalised?		Name and contact number of treating GP, Dentist or Specialist
			Yes	No	Yes	No	
			Yes	No	Yes	No	

8. **Endocrine** Have you or any of your dependants experienced problems or been diagnosed with conditions such as diabetes, under- or over-active thyroid, Cushing's Syndrome, Addison's Disease, pituitary gland or any other glandular problems? If yes, provide details. Yes No

Name of beneficiary	Diagnosis and date	Name of medication	Are you currently receiving treatment?		Have you been hospitalised?		Name and contact number of treating GP, Dentist or Specialist
			Yes	No	Yes	No	
			Yes	No	Yes	No	

9. **Back or muscles** (e.g. back and neck related conditions including injury, arthritis, gout, multiple sclerosis, knee or hip problems, osteoporosis etc.)
If yes, provide details. Yes No

Name of beneficiary	Diagnosis and date	Name of medication	Are you currently receiving treatment?		Have you been hospitalised?		Name and contact number of treating GP, Dentist or Specialist
			Yes	No	Yes	No	
			Yes	No	Yes	No	

10. **Neurological** (e.g. epilepsy, stroke, migraine, brain injuries, spinal cord injuries, paralysis, Cerebral Palsy, Multiple Sclerosis, mental retardation etc.) If yes, provide details. Yes No

Name of beneficiary	Diagnosis and date	Name of medication	Are you currently receiving treatment?		Have you been hospitalised?		Name and contact number of treating GP, Dentist or Specialist
			Yes	No	Yes	No	
			Yes	No	Yes	No	

SECTION 5 MEDICAL DETAILS *Continued*

11. **Psychological** (e.g. depression, anxiety, psychosis, suicide attempts, bipolar disorders, manic depression, Schizophrenia, Tourette's Syndrome, Anorexia Nervosa, received advice, counselling or hospitalisation for alcohol or drug abuse, etc.) If yes, provide details. Yes No

Name of beneficiary	Diagnosis and date	Name of medication	Are you currently receiving treatment?		Have you been hospitalised?		Name and contact number of treating GP, Dentist or Specialist
			Yes	No	Yes	No	
			Yes	No	Yes	No	

12. **Tumors or growths** (e.g. benign or malignant growths, lumps or tumours including melanoma, lymph gland cancer, leukaemia and breast cancer, or any other tumours, growths and cancers.) If yes, provide details. Yes No

Name of beneficiary	Diagnosis and date	Name of medication	Are you currently receiving treatment?		Have you been hospitalised?		Name and contact number of treating GP, Dentist or Specialist
			Yes	No	Yes	No	
			Yes	No	Yes	No	

13. **Blood and HIV** Do you or any of your dependants suffer from any blood disorders, immune deficiency state, HIV/AIDS, etc? If yes, provide details. Yes No

Name of beneficiary	Diagnosis and date	Name of medication	Are you currently receiving treatment?		Have you been hospitalised?		Name and contact number of treating GP, Dentist or Specialist
			Yes	No	Yes	No	
			Yes	No	Yes	No	

14. **Skin** (e.g. Eczema, acne, dermatomyositis, dermatitis, Pemphigus, Psoriasis, Scleroderma or any other skin disorders.) If yes, provide details. Yes No

Name of beneficiary	Diagnosis and date	Name of medication	Are you currently receiving treatment?		Have you been hospitalised?		Name and contact number of treating GP, Dentist or Specialist
			Yes	No	Yes	No	
			Yes	No	Yes	No	

15. **Sexually transmitted diseases** (e.g. Pelvic Inflammatory Disease (PID) etc.) If yes, provide details. Yes No

Name of beneficiary	Diagnosis and date	Name of medication	Are you currently receiving treatment?		Have you been hospitalised?		Name and contact number of treating GP, Dentist or Specialist
			Yes	No	Yes	No	
			Yes	No	Yes	No	

16. **Are you or any of your dependants pregnant?** If yes, provide details. Yes No

Name of beneficiary	Expected delivery date	Attending doctor

SECTION 6 EMPLOYER INFORMATION *This section must be completed by your employer*

Name of employer

Employee number

Employment date d d m m y y y y

Division code

Dept. name

Persal number *if applicable*

Fedhealth pay point code

Medical scheme start date d d m m y y y y

We confirm that the applicant is employed by us and commenced employment on the above date.

Employer telephone number c o d e

Employer fax number c o d e

Employer e-mail address

Name of medical scheme/ salary administrator

Designation

Company stamp

Signature ..... Date signed d d m m y y y y

SECTION 7 BUSINESS INFORMATION IF SELF-EMPLOYED

Name of business

Registration number

Type of business

Postal address

Postal code

Physical address

Postal code

Telephone (H) c o d e

Telephone (W) c o d e

Cellular

Fax c o d e

E-mail address

SECTION 8 BANK DETAILS OF PRINCIPAL MEMBER

Refund of claim and savings payments / debit order instruction

I instruct Medscheme to electronically collect contributions and to deposit claim and savings refunds, via the ACB system, using the information provided below. I understand that transfers cannot be done to and from credit card accounts. I also irrevocably authorise Medscheme to reverse any erroneous transactions and/or rectify any electronic transfer of funds error without prior notice.

☐ USE THIS ACCOUNT FOR ALL TRANSACTIONS

☐ USE THIS ACCOUNT FOR CONTRIBUTION COLLECTIONS ONLY

Bank name .....

Branch name .....

Bank branch code

Type of account CHEQUE TRANSMISSION SAVINGS

Name of account holder .....

Bank account number

☐ USE THIS ACCOUNT FOR CLAIMS AND SAVINGS REFUNDS ONLY

Bank name .....

Branch name .....

Bank branch code

Type of account CHEQUE TRANSMISSION SAVINGS

Name of account holder .....

Bank account number

Account holder's signature .....

Date d d m m y y y y

SECTION 9 DECLARATION BY PRINCIPAL MEMBER

1. I, the undersigned hereby apply for membership of Fedhealth Medical Scheme (hereinafter referred to as "the Scheme") and also nominate my dependants as specified. I hereby undertake to observe and carry out the provisions of the Medical Schemes Act (Act 131 of 1998) and of the rules of the Scheme as amended from time to time.
2. I agree that the Scheme shall not be bound in any way by any representations or undertakings made or given by any person or agent which is in contradiction with the registered rules of the Scheme.
3. I further agree that membership will not commence and no liability whatsoever will attach to the Scheme as a result of this application, unless and until the first contribution has been paid and received by the Scheme.
4. I hereby authorise and request any doctor or medical professional person, or any other person who may be in possession of, or may hereafter acquire, any information concerning my/the nominated dependants' health, whether such information relates to the past or future, to disclose such information to the Scheme or its administrator and agree that this authorisation and request shall remain in force after my/their deaths, as well as prior thereto. 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.
5. I accept any penalties that may be applied in accordance with the Medical Schemes Act of 1998. I understand that these penalties include a 3 month general waiting period, a 12 month waiting period for pre-existing conditions and, if applicable, a late joiner penalty fee.
6. I hereby authorise the Scheme to deduct from my salary or any other available funds via debiting of my bank account, all subscriptions or any other amounts that may become due by me in terms of the Scheme's rules. In the event of arrears, I will be responsible for any legal costs that may arise in the recovery thereof.
7. It is my sole responsibility as a member to ensure that the monthly premium is received by the Scheme.
8. I hereby acknowledge that any credit extended by the Scheme to myself or my dependants whilst being a member of the Scheme will become payable in full on termination of my membership and that interest may be charged on all amounts due and owing to the Scheme.
9. I understand that the Scheme may provide written notification, to my e-mail address, failing which, my broker's email address as supplied by my broker, of changes to its Rules.
10. I declare that this personal statement, whether in my handwriting or not is complete, true and correct and that I have not concealed, withheld or misstated any material facts.
11. I acknowledge that non-disclosure of any information by me or my dependants relevant to the assessment of this application shall render any contracts to which this application relates null and void, and all contributions paid by me shall be forfeited to the Scheme. In such events, the Scheme shall be entitled to reclaim any amounts which they may have paid to me or any person on my or my dependants' behalf under such contracts.
12. Should there be any additional information required by the Scheme which is not received within 7 days, the Scheme will automatically suspend the application.
13. I hereby authorise the Scheme or any of it's nominated representatives to confirm my bank details.
14. I hereby appoint the financial advisor who has submitted this application on my behalf, to be my nominated financial advisor.

Signed at ..... on this ..... day of .....20...

Signature of principal member .....

Print name ..... Identity number

STOP ORDER *For Persal members only*

I, the undersigned:

Full name .....

Rank ..... Salary number .....

Station (place of work) .....

Identity number | | | | | | | | | | | | | |

hereby authorise the Department of .....

to deduct R ..... (full premium), from my salary and to pay it to Fedhealth Medical Scheme,

Table: 057 Code: 0036 Effective date : .....20.., *Reference number* .....*(for office use only)*

from whom I have obtained Medical Scheme membership, until such time as I cancel this authorisation in writing, or until I substitute it with a new authorisation. Should the relevant premium be adjusted by the institution as a result of a general decrease/increase, or should I request the institution to decrease/increase the premium for certain reasons, I confirm that the adjusted premium (including stamp duty), may be deducted from my salary, until such time as I cancel this authorisation in writing, or until I substitute it with a new authorisation.

Signed at ..... on this ..... day of .....20 ...

Applicant's signature .....

PREVIOUS SCHEME CANCELLATION *For Persal members only*

I, ... hereby cancel my membership
Applicant's name

of ..... with effect from .....20 ...
Name of previous scheme

Membership number | | | | | | | | | | | |

Signed at ..... on this ..... day of .....20 ...

Applicant's signature .....

AUTHORISATION TO COLLECT FEES *Medway only*

1. I acknowledge that my financial adviser has agreed to render certain broker services to me arising from my membership of Fedhealth Medical Scheme (Maxima Option), for a fee of R30,00 per month as provided for in regulation 28(6) (b) of the Medical Schemes Act.
2. The broker services that my financial adviser has agreed to render to me include, but are not limited to:
   - 2.1 handling enquiries in relation to my membership of Fedhealth
   - 2.2 keeping Fedhealth informed of changes in my membership details
   - 2.3 informing me of changes in my contribution to Fedhealth, and
   - 2.4 advising me of changes to the product and benefits that Fedhealth offers.
3. This fee may be reviewed annually when my contribution to the Fedhealth Maxima Option is reviewed and increased by a rate based on the average contribution increase. I will receive reasonable written notification of such intended change.
4. The agreement will start when I become a member of the Fedhealth Maxima Option and will end when my financial adviser is not entitled to receive compensation for my membership of Fedhealth for any reason whatsoever.
5. *I acknowledge that this fee will not form part of my contribution to the Fedhealth Maxima Option and will therefore be a separate charge.*
6. I instruct Medway to collect this fee, on the due date, in terms of the payment details given in this application and pay my financial adviser on my behalf.
7. I instruct Medway to collect this fee from the following banking account.

Bank name .....

Branch name .....

Bank branch code | | | | | | | |

Type of account CHEQUE | TRANSMISSION | SAVINGS

Name of account holder .....

Bank account number | | | | | | | | | | | | | |

Name and surname of principal member | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Name of broker or brokerage | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Broker code | | | | | | | | |

Signature of principal member ..... Date d d m m y y y y

ONLY COMPLETE THIS SECTION IF YOU OR ONE OF YOUR DEPENDANTS HAS BEEN PRESCRIBED CHRONIC MEDICATION , YOUR MEMBERSHIP HAS BEEN APPROVED AND THE SCHEME HAS NOT APPLIED A WAITING PERIOD ON THE CONDITION REQUIRING CHRONIC MEDICATION.

SOLUTIO MEDICINE MANAGEMENT
CHRONIC MEDICINE BENEFIT APPLICATION FORM

TELEPHONE 0860 100 608

PLEASE FAX COMPLETED FORM WHERE POSSIBLE TO : 0800 223 670 / 680
OR MAIL TO SOLUTIO, P O BOX 38632, PINELANDS, 7430

NOTE: 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.

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.

TO BE COMPLETED BY THE APPLICANT

MEMBER DETAILS:

Member's first name | Surname | Title

Medical Scheme | Option/ Plan

Membership number

PATIENT'S DETAILS:

Patient's first name | Surname | Title

I.D. Number | Date of birth d d m m y y y y | Beneficiary Code

Telephone numbers (H) c o d e | (W) c o d e | Cell

E-mail address | Fax c o d e

Postal address

c o d e

MEDICINE SUPPLIER: i.e. pharmacy or dispenser

Name | Telephone c o d e

E-mail address | Fax c o d e

OTHER MEDICAL PRACTITIONER OR SPECIALIST that you are seeing in addition to the doctor completing this form.

Name of doctor | Telephone c o d e

Speciality | Fax c o d e

I/we understand that all personal and clinical information supplied to Solutio Medicine Management will be kept confidential. Solutio Medicine Management 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 medical practitioner, hospital, clinic and/or medical facility in possession of any medical information regarding myself, the applicant and any dependant, to provide Solutio Medicine Management from time to time, with such information that they may require.

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

MEMBER'S SIGNATURE: ..... Date d d m m y y y y

PATIENT'S SIGNATURE: .....
(not required if patient is a minor)

MEMBER/PATIENT SIGNATURE IS ESSENTIAL IN ORDER TO PROCESS THIS APPLICATION

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

DETAILS OF THE ATTENDING MEDICAL PRACTITIONER

Doctor's surname | Initials | Qualifying degree

Practice number | HPCSA Reg.No.

Postal address

c o d e

E-mail address

Telephone c o d e | Cell | Fax c o d e

PLEASE ENSURE THAT YOUR PATIENT IS APPLYING FOR THE FIRST TIME. THE COMPLETION OF ONLY ONE APPLICATION WILL BE PAID FOR.

1. CLINICAL EXAMINATION: General Information

Female | Male

Weight kg

Height cms

Latest blood pressure (on current therapy)

/ mm Hg(sitting, having rested for 5 minutes)

Please complete the following if the patient has asthma (indicate baseline function over the past 3 months):

Daytime symptoms	≤ 2 x/wk	2-4 x/wk	>4 x/wk	More or less continuous			
Night-time symptoms	≤1 x/mth	2-4 x/mth	>4 x/mth	Frequent	PEFR (% of predicted)	≥ 80%	60-80%	<60%

2. RISK FACTORS:

Smoking: yes | no

Physical Activity: Little | Regular | Very Active

Please indicate if the patient has a history of the following:

Ischaemic Heart Disease: yes | no

Peripheral Vascular Disease: yes | no

TIA/Stroke: yes | no

First degree relative with premature heart disease (PREMATURE = MI IN FEMALES <65YRS; MALES <55YR: yes | no

Definite diagnosis of familial hypercholesterolaemia: yes | no

If the patient has diabetes, please provide the most recent HbA1c results.

3. DRUG ALLERGIES:

Please specify

.....

.....

DO NOT SUBMIT WITH YOUR APPLICATION FORM

CONDITIONS AND MEDICINES FOR WHICH PAYMENT IS REQUESTED Please indicate where you agree to generic substitution and give your preferential drug's name.
Where diagnosis was confirmed by investigation, kindly supply the most recent results as well as results prior to commencement of therapy e.g. TC, LDL and HDL for hypercholesterolaemia.

Detailed diagnosis to allow for ICD 10 disease coding	Medicine Trade Names	Generic Substitution		Strength (e.g. 10mg)	Directions (e.g. 1tds)	Period in Use (years)	Special investigation results in support of diagnosis		
		Yes	No				Type	Date Performed	Results
Condition 1									
Condition 2									
Condition 3									
Condition 4									

Motivation in support of the payment of specific drugs as requested above.	Medicine Trade Names	Motivations

ACKNOWLEDGEMENT BY EXAMINING DOCTOR

I certify that the particulars hereto are - to the best of my knowledge and belief - true and accurate, having conducted a personal examination and/or procured the tests and/or other diagnostic investigations referred to.
I acknowledge that Solutio Medicine Management will rely on such particulars when making any recommendations regarding payment of ongoing/chronic medication to the relevant Medical Scheme.

This refers specifically to patient : Surname: First Name:

Date: d d m m y y y y

DOCTOR'S SIGNATURE : .....