SIZWE HOSMED MEDICAL SCHEME
Your choice for quality care

CHRONIC MEDICINE PROGRAMME APPLICATION

Broker House: Aon South Africa (Pty) Ltd
Tel No: 0860 100 404
Broker Code: 1009

HOW TO COMPLETE THIS FORM

NOTE: It is important that this form is completed in full, incomplete forms WILL NOT be processed and may cause a delay in members receiving their medication.

- The patient or principal member must complete section 1 in full, incomplete forms will NOT be processed.
- Section 2-4 must be fully completed by the doctor to ensure efficient processing.
- Completed forms may be faxed or e-mailed to: 011 353 0076/ chronic@sizwehosmed.co.za.

SECTION 1 TO BE COMPLETED BY PATIENT OR PRINCIPAL MEMBER

MEMBER'S DETAILS

Select Plan: Drive Plan / Drive Plus Plan

Membership Number:

Surname: Title: Initials:

PATIENT'S DETAILS

First Name(s): (as per ID)

Surname: Title: Initials:

Date of birth:

Population group: African Coloured Indian White Asian

Address:

Code

Tel (work): Cell:

Tel (home):

Email:

I hereby give permission for my doctor to provide Sizwe Hosmed Medical Scheme with my diagnosis and other relevant clinical information required to review my application. I understand that funding from chronic benefit is subject to clinical criteria and drug utilisation review as determined by Sizwe Hosmed Medical Scheme. By registering on the programme, I accept that due to my chronic condition I may be subject to wellness management interventions and periodic review and that this may include access to my medical records. Generic medication or therapeutic alternatives can significantly reduce prescription costs, while still providing the desired therapeutic effect. Should a suitable generic equivalent be available, Sizwe Hosmed Medical Scheme will only reimburse to the value of these alternatives

NOTE: Treatment for Prescribed Minimum Benefit (PMB) conditions will be approved in accordance with Sizwe Hosmed Medical Scheme formularies

Member's Signature: _____ Date:

BROKER DETAILS:

Brokerage Name:

Full Name & Surname of Broker: (as per ID)

Tel:

Email:

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SECTION 2 GENERAL INFORMATION (TO BE COMPLETED BY DOCTOR)

Weight (kg): ____,____ Height (m): ____,____ BMI: ____,____

Is the patient post-menopausal (female)? ☐ Yes ☐ No

Smoking status: ☐ Smoker ☐ Ex- smoker ☐ Non-smoker

Liquor intake: ☐ Daily ☐ Weekly ☐ Occasionally

Exercise: ☐ Not really ☐ > 3 hours per week

Allergies (specify): _____

Details of hospital admission in the past year: _____

_____

_____

SECTION 3 TO BE COMPLETED BY TREATING PROVIDER

NOTE: Please attach appropriate diagnostic tests that were performed to confirm the chronic illness(es) that the patient suffers from, e.g. Pathology results, bone density reports, ECG reports, criteria for rheumatoid arthritis.

Diabetes Mellitus

Initial venous glucose result: _____ HBA1C result: _____

Hypertension

Average blood pressure reading (mmHg): _____ Latest blood pressure reading (mmHg): _____

Hyperlipidaemia

Please attach INITIAL lipogram report.

Cardiovascular disease

Please specify family or personal history of cardiovascular disease:

_____

_____

Chronic renal failure

Creatinine clearance result:

_____

_____

Please attach other relevant pathology reports for the use of erythropoetin or iron replacement.

Glaucoma

Intra-ocular pressure reading: ☐ Left ☐ Right

PEF (L/min): _____ FEB (L): _____

Use of bronchodilator per day: ☐ Times Limitations on daily activities: ☐ Yes ☐ No

Using home oxygen: ☐ Yes ☐ No

Schizophrenia

Please include DSM IV criteria

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SECTION 4: TO BE COMPLETED BY TREATING PROVIDER

ICD-10 Code (diagnosis)	Medication name, strength and dosage	Date initiated	Previous medication and reason for changes
		/ /	
		/ /	
		/ /	
		/ /	
		/ /	
		/ /	

Surname: _____ Initials: _____ Practice number: _____

Specialty: _____

ACKNOWLEDGEMENT BY EXAMINING DOCTOR

I hereby certify that the particulars hereto are – to the best of my knowledge – true and accurate, having conducted a personal examination and/or procured the tests and/or other diagnostic investigations referred to.

Doctor's signature: _____ Date: [ ]

SECTION 5 SCHEME DECLARATION

As Sizwe Hosmed Medical Scheme we are strongly committed to protecting your personal data. We are required by POPIA to explain why and how we collect, use, and disclose your personal information, which may include health and financial information. Sizwe Hosmed Medical Scheme and its administrator (3Sixty Health (Pty) Ltd) will keep your information supplied to us in this application confidential. Acceptance of these terms and conditions is a requirement for activation and servicing of your medical scheme membership. You give us consent to process your personal information for the following purposes:

a) Administration of your health care option;
b) Provision of managed care services to you;
c) Providing relevant information to a contracted third party;
d) To profile and analyse risk;
e) For research purposes and;
f) To comply with legislation.

Please note that we will only share your information with a third party if you have granted us your consent for the disclosure of the information to such third party or if a contractual relationship exists in terms of which we are obliged to provide your information to such third-party. We may amend this notice from time to time, please check our website to inform yourself of any changes.