APPLICATION FORM
PRESCRIBED MINIMUM BENEFIT (PMB) TREATMENT PLAN

IMPORTANT TO NOTE BEFORE COMPLETING THIS FORM

For the patient:
- Please book an appointment with your treating doctor so that he/she can examine you and assist you in completing this application form.

For the treating doctor:
- Please assist in completing this application if your patient has been diagnosed with a PMB chronic condition and is **not** on chronic medication.
- Should your patient require authorisation of medication, please advise them to complete a chronic medication application via the Fund's Chronic Medicine Risk Management Programme.

Please take note of the following:
- The information contained in this application form is used to draw up your PMB treatment plan.
- Treatment and care is strictly for the 26 PMB chronic disease list (CDL) conditions. Please ensure that your treating doctor includes the correct ICD-10 codes to ensure that your claims are paid from the appropriate benefit.
- If you or your beneficiary are authorised for a PMB treatment plan during the course of the year, the services outlined in the treatment plan will be granted on a pro rata basis.

PLEASE USE BLOCK LETTERS FOR ALL SECTIONS

1. MEMBER AND PATIENT INFORMATION

TO BE COMPLETED BY THE APPLICANT

MAIN MEMBER DETAILS

Membership number

Benefit option ☐ Select Plan ☐ Prime Plan ☐ Guardian Plan

Title | Initials | ID number

Full name and surname

Email address

PATIENT DETAILS

Dependant code

Title | Initials | ID number

Full name and surname

Contact numbers | Home | Work

Cell phone

Postal address

Postal code

Email address

Membership number | **Doctor's practice number**

1. MEMBER AND PATIENT INFORMATION (CONTINUED)

TO BE COMPLETED BY THE APPLICANT (CONTINUED)

PATIENT CONSENT

I understand that Transmed Medical Fund (Transmed) and Momentum Health Solutions, the Administrator, will maintain the confidentiality of my personal information and comply with the Protection of Personal Information Act 4 of 2013 (POPIA) and all existing data protection legislation, when collecting, processing and storing my personal information for the purposes of registration for a PMB treatment plan.

I understand that:

- Funding for this benefit is subject to meeting benefit entry criteria requirements as determined by the Fund.
- The benefit provides cover for therapy scientifically proven for my condition, which means that not all medication for the condition will automatically be covered.
- By registering for the 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.
- Funding will only be effective once the Fund receives an application form that is completed in full.
- Payment to the healthcare professional for the completion of this form, on submission of a claim, will be subject to the Fund rules and where the member is a valid and active member at the service date of the claim.
- 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 to make informed funding decisions.
- To ensure that we pay your claims from the correct benefit, any claims from your healthcare providers must include the relevant ICD-10 diagnosis code(s). Please ask your doctor to also include the relevant ICD-10 diagnosis code(s) on the referral form for any pathology and/or radiology tests. This will enable the pathologists and radiologists to also include the relevant ICD-10 diagnosis code(s) on the claims they submit, thus further ensuring that we pay your claims from the correct benefit.

CONSENT FOR PROCESSING MY PERSONAL INFORMATION

1. I hereby acknowledge that Transmed has appointed Momentum Health Solutions (Pty) Ltd as the administrator of the programme and that any prescribed medical treatment shall be the sole responsibility of my medical practitioner. I understand that the information provided on this form shall be treated as confidential and will not be used or disclosed except for the purpose for which it has been obtained.
2. I hereby give my consent to the Fund, Momentum Health Solutions and its employees to obtain my, or any of my dependants', special personal information (including general, personal, medical or clinical), whether it relates to the past or future (e.g. health and biometric) from any of my healthcare providers (e.g. pharmacist, pathologist, radiologist, treating doctor and/or specialist) to assess my medical risk, enrol me on the programme and to use such information to my benefit and to undertake managed care interventions related to my chronic condition(s).
3. I understand that this information will be used for the purposes of applying for and assessing my funding request for chronic benefits.
4. I give permission for my healthcare provider to provide the Fund and the administrator with my diagnosis and other relevant clinical information required to review and process my application.
5. I consent to the Fund and the administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical) to my healthcare provider, to administer the chronic benefits.
6. Whilst Momentum Health Solutions undertakes to take all reasonable precautions to uphold the confidentiality of information disclosed to it, I am aware that the Fund and my healthcare provider (where necessary) shall also gain access to the same information. I shall therefore not hold Momentum Health Solutions and its employees or the Fund and its trustees, liable for any claims by me or my dependants arising from any unauthorised disclosure of my special personal information to other parties.
7. I understand and agree that special personal information relevant to my current state of health may be disclosed to third parties for the purpose of scientific, epidemiological and/or financial analysis without disclosure of my identity.

I hereby certify that the information provided in this application is true and correct.

Member/patient signature
(or signature of parent/ guardian if patient is under the age of 18)

Date
DD/MM/YYYY

Membership number

Doctor's practice number

2. MEDICAL PRACTITIONERS' INFORMATION

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

DOCTOR DETAILS

Practice number

Initials | Speciality

Surname

Contact numbers | Work | Fax

Cell phone

Postal address

Postal code

Email address

3. CLINICAL EXAMINATION

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

Gender ☐ Male ☐ Female ☐ Other | Weight ____ kg | Height ____ cm

Blood pressure (on treatment) ____ / ____ mmHg | Blood pressure (off treatment) ____ / ____ mmHg

Smoker ☐ Never ☐ Ex-smoker ☐ <10 per day ☐ >10 per day

Exercise ☐ Never ☐ <1 hour per week ☐ 1-3 hours per week ☐ >3 hours per week

Allergies ☐ Penicillin ☐ Aspirin ☐ Sulphonamides

Other

Please note that clinical information is mandated prior to the authorisation of a PMB treatment plan and when additional services are required.

PRESCRIBED MINIMUM BENEFITS

Please indicate which conditions your patient has.

- ☐ Addison's disease
- ☐ Asthma
- ☐ Bipolar mood disorder
- ☐ Bronchiectasis
- ☐ Cardiac failure
- ☐ Cardiomyopathy disease
- ☐ Chronic obstructive pulmonary disorder (COPD)
- ☐ Chronic renal disease
- ☐ Coronary artery disease
- ☐ Crohn's disease
- ☐ Diabetes insipidus

Membership number | **Doctor's practice number**

3. CLINICAL EXAMINATION (CONTINUED)

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER (CONTINUED)

PRESCRIBED MINIMUM BENEFITS (CONTINUED)

Please indicate which conditions your patient has.

- ☐ Diabetes mellitus type 1
- ☐ Diabetes mellitus type 2
- ☐ Dysrhythmias
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Haemophilia
- ☐ Hyperlipidaemia (high cholesterol)
- ☐ Hypertension (high blood pressure)
- ☐ Hypothyroidism
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Rheumatoid arthritis
- ☐ Schizophrenia
- ☐ Systemic lupus erythematosus
- ☐ Ulcerative colitis

If your patient is at risk of being HIV positive, or has been diagnosed as a person living with HIV/AIDS, please advise them to register on the HIV **YourLife** Programme on 0860 109 793 (all calls are confidential).

Membership number _____ **Doctor's practice number** _____

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