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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: Initials: Surname:

Names in full (as per identity document):

Date of birth: E-mail:

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

Sex: Language preference:

The outcome of this application must be communicated to me via

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:

Please complete and fax to 086 577 0274 or email to pam.jubileus@platinumhealth.co.za

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?

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:

2. / mmHg Date:

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.

- | | | |
|---|--|--|
| <input type="checkbox"/> Left ventricular hypertrophy | <input type="checkbox"/> Myocardial infarction | <input type="checkbox"/> Hypertensive retinopathy |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Chronic renal disease | <input type="checkbox"/> Prior CABG (Coronary artery bypass graft) |
| <input type="checkbox"/> Stroke TIA | <input type="checkbox"/> Peripheral arterial disease | <input type="checkbox"/> 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:

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> Xanthelasma | <input type="checkbox"/> Cerebrotendinous xanthomastosis | <input type="checkbox"/> Arcus Cornealis |
|--------------------------------------|--|--|

Secondary prevention

Please indicate the condition(s) your patient has:

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

Please complete and fax to 086 577 0274 or email to pam.jubileus@platinumhealth.co.za

Platinum Health membership number:

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Patient name and surname:

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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 ENSURE 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:

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BHF practice number:

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Date:

C	C	Y	Y	M	M	D	D
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Speciality:

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Tel no (Practice):

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Doctor's signature:

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