Contact us
Tel: 0800 BANKMED (0800 226 5633) • Private Bag X2, Rivonia 2128 • www.bankmed.co.za

Medication Advisory Services (Chronic Medication Programme) Enrolment Form

Please note this application form should be completed by members on the Core Saver, Traditional, Comprehensive and Plus Plans.

Who we are

Bankmed (referred to as 'the Scheme'), registration number 1279, is a non-profit organisation, registered with the Council for Medical Schemes. Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07) which takes care of the administration of your membership for the Scheme.

How to complete this form

Please complete the appropriate sections as indicated:

1. For enrolment onto the Chronic Medication Programme, please complete all sections of this application form, i.e. sections A to G
2. Once completed please return the form by e-mail to chronic@bankmed.co.za or fax it to 011 770 6247
3. Alternatively for Chronic Medication authorisations, contact 0800 BANKMED (0800 226 5633)

Please note that this form excludes application for enrolment onto the oncology (cancer), HIV/AIDS and maternity (Baby-and-Me) programmes.

Section A: member/patient details

To be completed by the applicant
Member details:

Plan type | Membership number

Title | ID number or date of birth

Surname

First name/s

E-mail address

Patient details:

First name(s)

Surname

Dependant code | ID or date of birth

Postal address

Postal code

E-mail address

Telephone (H) (W)

(C) Preferred contact method: E-mail or Fax

Section B: Healthcare Professional's details and consent

Full name(s)

Surname

Practice number Speciality

Physical address

Postal code

E-mail address

Telephone (W) (F)

(C) Preferred contact method: E-mail or Fax

I confirm that, to my knowledge, the clinical details described in this document are accurate and correct. I understand that the Performance Health treatment protocols are guidelines only and that the ultimate responsibility regarding treatment and general management of my patient's condition resides with me. The reimbursement of therapy and related costs by the Scheme will be in accordance with the guidelines as well as the benefits available to the above patient from time to time.

Healthcare Professional's signature

Date Y Y Y Y M M D D

Section C: clinical examination

To be completed by attending Healthcare Professional

Gender: Male Female

Measurements: waist circumference cm weight kg height cm

(Waist measurement to be omitted in the case of pregnancy)

Smoking: Yes No **Stopped:** less than 12 months ago more than 12 months ago

Exercise: Never less than 1 hour/week 1-3 hours/week more than 3 hours/week

Allergies: penicillin asprin sulphonamides

other

Section D: clinical information

To be completed by attending Healthcare Professional

Diagnosis (ICD-10 CODES)	Description	Date of diagnosis
Primary:		
Other:		

Results		Test date
Blood glucose results* Hba1C		
Reading 1	%	D D M M Y Y Y Y
Reading 2	%	D D M M Y Y Y Y
Reading 3	%	D D M M Y Y Y Y
Blood glucose**		
Reading 1	mmol/l	D D M M Y Y Y Y
Reading 2	mmol/l	D D M M Y Y Y Y
Reading 3	mmol/l	D D M M Y Y Y Y
Lipogram results* Total cholesterol		
Reading 1	mmol/l	D D M M Y Y Y Y
Reading 2	mmol/l	D D M M Y Y Y Y
Reading 3	mmol/l	D D M M Y Y Y Y
Low-density lipoproteins (LDL)		
Reading 1	mmol/l	D D M M Y Y Y Y
Reading 3	mmol/l	D D M M Y Y Y Y
Reading 3	mmol/l	D D M M Y Y Y Y
Triglycerides (Tg)		
Reading 1	mmol/l	D D M M Y Y Y Y
Reading 2	mmol/l	D D M M Y Y Y Y
Reading 3	mmol/l	D D M M Y Y Y Y
Respiratory results* Forced expiratory volume (FEV1%)		
Reading 1	%	D D M M Y Y Y Y
Reading 2	%	D D M M Y Y Y Y
Reading 3	%	D D M M Y Y Y Y
Peak flow		
Reading 1	%	D D M M Y Y Y Y
Reading 2	%	D D M M Y Y Y Y
Reading 3	%	D D M M Y Y Y Y
Cardiac results* Blood pressure		
Reading 1	mmHG	D D M M Y Y Y Y
Reading 2	mmHG	D D M M Y Y Y Y
Reading 3	mmHG	D D M M Y Y Y Y

*Please indicate whether any of these results were recorded “on treatment” (i.e. not baseline values)
**Please indicate whether these are fasting or random glucose levels

Additional information relevant to your patient's condition(s):

Section E: chronic medication application

To be completed by attending Healthcare Professional

Please note that in order to comply with clinical funding protocols, the receipt of certain clinical information is mandated prior to the authorisation of chronic medication. This includes, but is not limited to, the following:

Asthma:	Diagnostic lung function tests/paediatrician report
Chronic Obstructive Airways Disease:	Diagnostic lung function tests
Bipolar Mood Disorder & Schizophrenia:	Confirmation of diagnosis by a psychiatrist
Cardiac failure & Cardiomyopathy:	NYHA stage
Chronic Kidney Disease:	Creatinine Clearance/e-GFR/Albumin-Creatinine Ratio
Diabetes mellitus:	Diagnostic fasting or random blood glucose
Haemophilia:	Factors VIII and IX blood levels
Hyperlipidaemia:	Diagnostic fasting Lipogram*
Hypertension:	Diagnostic blood pressure readings**
Hypothyroidism:	Diagnostic thyroid function tests (TSH and T4)***

In addition, Bankmed requires certain special investigations to expedite the chronic authorisations process. This includes, but is not limited to, the following:

Insulin for Diabetes type 2:	HbA1c and motivation
DPP-4 inhibitors and GLP-1 analogues:	HbA1c and motivation
Glitazones and SGLT2 inhibitors:	HbA1c and motivation
Osteoporosis treatment:	DEXA scan and motivation

* In primary prevention patients requesting lipid-modifying therapy (e.g. statins), reimbursement is reserved for patients with a significant risk of an acute clinical coronary event within the next 10 years, as calculated by the Framingham Risk Calculation and in accordance with locally and internationally accepted treatment guidelines. Please note that generic simvastatin is the preferred statin in these instances.

** At least two pre-treatment readings required, separated by 3-6 months, unless BP is severely increased. Lifestyle modification is strongly advised as a first line treatment and in addition to medication.

*** Both the pre-treatment TSH and T4 levels are required; in the case of sub-clinical hypothyroidism, a supporting motivation and/or laboratory report indicating anti-thyroid antibody levels is required

Medication prescribed

Please use block letters. Kindly indicate below where you agree to a generic substitution and provide your preferred medication name.

ICD-10 code(s)	Diagnosis	Name (trade name or generic equivalent)	Generic substitution		Strength (e.g. 50mg)	Directions (e.g. 2tds)	Date Medication started	Type and date of investigation/report
			Yes	No				
			Y	N				
			Y	N				
			Y	N				
			Y	N				
			Y	N				
			Y	N				
			Y	N				

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Additional information/motivation

PLEASE NOTE: All chronic medication is subject to the Maximum Medical Aid Price (MMAP). Should the patient be unable to use a preferred alternative, the prescribing Healthcare Professional would need to submit a detailed clinical motivation including outcomes/adverse reactions experienced in response to treatment using the preferred alternate agents.

Medication stopped (please use block letters)

ICD-10 code(s)	Diagnosis	Name (trade name or generic equivalent)	Strength (e.g. 50mg)	Directions (e.g. 2tds)	Date Medication stopped
					D D M M Y Y Y Y
					D D M M Y Y Y Y
					D D M M Y Y Y Y
					D D M M Y Y Y Y
					D D M M Y Y Y Y
					D D M M Y Y Y Y
					D D M M Y Y Y Y
					D D M M Y Y Y Y

Section F: Prescribed Minimum Benefits

To be completed by attending Healthcare Professional

If your patient has one or more of the following chronic conditions, he/she may qualify for additional services. Please indicate which condition(s) he/she has by placing an "X" next to the applicable condition.

☐	Addison's Disease	☐	Crohn's Disease	☐	Hypertension
☐	Asthma	☐	Diabetes Insipidus	☐	Hypothyroidism
☐	Bipolar Mood Disorder	☐	Diabetes Mellitus Type I	☐	Multiple sclerosis
☐	Bronchiectasis	☐	Diabetes Mellitus Type II	☐	Parkinson's Disease
☐	Cardiac Failure	☐	Dysrhythmias	☐	Rheumatoid Arthritis
☐	Cardiomyopathy Disease	☐	Epilepsy	☐	Schizophrenia
☐	Chronic Obstructive Pulmonary Disorder	☐	Glaucoma	☐	Systemic Lupus Erythematosus
☐	Chronic Renal Disease	☐	Haemophilia	☐	Ulcerative colitis
☐	Coronary Artery Disease	☐	Hyperlipidaemia		

Section G: patient consent

1. I hereby confirm that the information provided in this application is true and correct.
2. I acknowledge that the Bankmed Medical Scheme ("Bankmed") has appointed Performance Health (Pty) Ltd, a subsidiary of MediKredit Integrated Healthcare Solutions (Pty) Ltd to manage the Chronic Medication Programme and that any medical treatment prescribed, as well as the general management of my condition(s), will be the sole responsibility of my healthcare provider(s), in consultation with me. Performance Health and Bankmed (collectively, the "Bankmed Parties") will accordingly not be liable for any claims by me or my dependants arising from the implementation of the Programme, save insofar as provided in the Bankmed Rules.
3. I hereby give my consent to the Bankmed Parties and its staff to obtain my Special Personal Information (i.e. health and biometric), to assess my medical risk and to use such information to my benefit. I understand and agree that Special Personal Information relevant to my current state of health can be disclosed to third parties for the purpose of scientific, epidemiological and/ or financial analysis, without disclosure of my identity. I furthermore agree to the Programme's consultants sharing my Special Personal Information with any other healthcare provider involved in my care (including the Hospital Advisory Services professionals appointed by Bankmed).
4. I understand that no information regarding my case will be made available to my employer(s) or any other person not directly involved in my care.
5. I give my consent to the Bankmed Parties to electronically store, access, process and retain my healthcare information for the purposes set out in this document as may otherwise be required to administer the Programme.
6. Whilst the Bankmed Parties will use their best endeavours to uphold the confidentiality of all my Special Personal Information, the Bankmed Parties will not be liable for any claims by me or my dependants arising from any unauthorised disclosure of my Special Personal Information to a third party.
7. I understand that telephone calls will be recorded for internal clinical quality assurance purposes and will not be shared outside of the Medication Management Programme department.
8. I understand and acknowledge that "consent", for the purposes of this document, means my informed consent, in other words:
   8.1. I have read and understood the contents of this document.
   8.2. I understand and acknowledge the nature of the Special Personal Information that will be made available to and disclosed, used, processed and retained by service providers, as set out in this consent.
   8.3. I understand and acknowledge the purpose for which the Special Personal Information relating to me will be made available to, and disclosed, used, processed and retained by the Bankmed Parties and my healthcare provider(s), as set out in this consent.
   8.4. I have the legal capacity to give my informed consent, in other words, I am over the age of 18 years and am able to fully understand and make decisions about my healthcare.

Patient's signature

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

Date D D M M Y Y Y Y