

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	<input type="text"/>	Membership number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Title	<input type="text"/>	Date of birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ID or passport number	<input type="text"/>																
Surname	<input type="text"/>																
First name/s	<input type="text"/>																
E-mail address	<input type="text"/>																

Patient details:

First name(s)	<input type="text"/>																			
Surname	<input type="text"/>																			
Dependant code	<input type="text"/>	Date of birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>			
ID or passport number	<input type="text"/>																			
Postal address	<input type="text"/>																			
	<input type="text"/>															Postal code	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
E-mail address	<input type="text"/>																			
Telephone (H)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>			
Cellphone	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>			

Section B: Healthcare Professional's details and consent

Full name(s)																
Surname																
Practice number												Speciality				
Physical address																
												Postal code				
E-mail address																
Telephone (W)																
Cellphone																

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						
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Section C: Clinical examination

To be completed by the attending Healthcare Professional

Gender:	Male	<input type="checkbox"/>	Female	<input type="checkbox"/>											
Measurements:	waist circumference				cm	weight				kg	height				cm
	(Waist measurement to be omitted in the case of pregnancy)														
Smoking:	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Stopped:	<input type="checkbox"/>	less than 12 months ago	<input type="checkbox"/>	more than 12 months ago						
Exercise:	<input type="checkbox"/>	Never	<input type="checkbox"/>	less than 1 hour/week	<input type="checkbox"/>	1-3 hours/week	<input type="checkbox"/>	more than 3 hours/week							
Allergies:	<input type="checkbox"/>	penicillin	<input type="checkbox"/>	asprin	<input type="checkbox"/>	Sulphonamides									
Other															

Section D: Clinical Information

To be completed by the attending Healthcare Professional

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

Results		Test date											
Blood glucose results*													
Hba1C													
Reading 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	%	D	D	M	M	Y	Y	Y	Y
Reading 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	%	D	D	M	M	Y	Y	Y	Y
Reading 3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	%	D	D	M	M	Y	Y	Y	Y
Glucose Tolerance Test													
Reading 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	%	D	D	M	M	Y	Y	Y	Y
Reading 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	%	D	D	M	M	Y	Y	Y	Y
Reading 3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	%	D	D	M	M	Y	Y	Y	Y
Fasting 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 2		mmol/l				D	D	M	M	Y	Y	Y	Y
Reading 3		mmol/l				D	D	M	M	Y	Y	Y	Y
High-density lipoproteins (HDL)													
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
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
Fasting Reading 3		mmol/l				D	D	M	M	Y	Y	Y	Y
Respiratory results*													
FEV1/FVC readings													
Reading 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	%	D	D	M	M	Y	Y	Y	Y
Reading 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	%	D	D	M	M	Y	Y	Y	Y
Reading 3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	%	D	D	M	M	Y	Y	Y	Y
FEV1% pre bronchodilator													
Reading 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	%	D	D	M	M	Y	Y	Y	Y
Reading 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	%	D	D	M	M	Y	Y	Y	Y
Reading 3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	%	D	D	M	M	Y	Y	Y	Y
FEV1% post bronchodilator													
Reading 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	%	D	D	M	M	Y	Y	Y	Y

Results				Test date							
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 the 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:

Clinical entry criteria for prescribed minimum benefits (PMB)

Condition	Clinical Entry Criteria (please include the ICD10 code)
Addison's Disease	Diagnosis to be confirmed by an endocrinologist, paediatrician or specialist physician
Asthma	1. Diagnostic lung function test (pre- & post-bronchodilator) for children ≥7 years old and for all adults 2. For children <7 years of age, a confirmation of diagnosis from a paediatrician, pulmonologist or specialist physician is required
Bipolar Mood Disorder	Diagnosis to be confirmed by a psychiatrist and clinical subtype (type I or type II) to be specified
Bronchiectasis	Diagnosis to be confirmed by a pulmonologist or specialist physician
Cardiac Failure	New York Heart Association (NYHA) stage and left ventricular ejection fraction (LVEF) required
Cardiomyopathy	Subtype and left ventricular ejection fraction (LVEF) required
Chronic Obstructive Pulmonary Disease (COPD)	1. Diagnostic Lung Function Test reflecting both pre- and post-bronchodilator FEV1 and FEV1/FVC
Chronic Renal Failure	1. Diagnostic creatinine clearance or estimated Glomerular Filtration Rate (eGFR) 2. Hb results and iron studies required when applying for erythropoietin or intravenous iron
Coronary Artery Disease	Report with diagnostic findings required – e.g., ECG (exercise/stress), echocardiography, angiography, or details of cardiac event (ACS/MI/PCI/CABG, including date)
Crohn's Disease	Diagnosis to be confirmed by a gastroenterologist, surgeon or specialist physician
Diabetes Insipidus	Diagnosis to be confirmed by an endocrinologist, paediatrician or specialist physician

Diabetes Mellitus Type 1 & 2	Fasting blood glucose, and either the 2hr–OGTT, HbA1c (DCCT) or random blood glucose result are required (laboratory report); motivation including presenting symptoms required if only one test result provided
Dysrhythmias	Diagnosis to be confirmed by a cardiologist or specialist physician
Epilepsy	Diagnosis to be confirmed by a neurologist, specialist physician or paediatrician; alternatively, the seizure history or abnormal EEG report to be provided
Glaucoma	Diagnosis to be confirmed by an ophthalmologist
Haemophilia (A & B)	1. Diagnosis to be confirmed by a specialist physician or haematologist 2. Pathology report indicating factor VIII or IX levels
Hyperlipidaemia	1. Diagnostic Lipogram required – Must include Total Cholesterol, LDL, HDL and Triglyceride values 2. Blood pressure reading at time of diagnosis 3. Smoking status 4. Familial hyperlipidaemia requires an endocrinologist diagnosis 5. If applicable, please provide family history of premature cardiovascular event (detail required)
Hypertension	Two diagnostic blood pressure readings without any antihypertensive medication are required (the second reading to be 3 or more months after lifestyle modifications have been implemented) for newly diagnosed patients, unless diagnostic BP is $\geq 160/100$ or significant CV risk factors present (please provide details thereof if applicable)
Hypothyroidism	Diagnostic thyroid function test results: TSH and FT4; thyroid antibody tests in case of sub-clinical results
Multiple Sclerosis	1. Diagnostic confirmation from a neurologist or specialist physician 2. The following information must be submitted: a. MRI reports b. Relapsing-remitting history (clinical presentation and dates) c. Extended Disability Status Score (EDSS) d. Relapses requiring cortisone therapy e. Current Functional Systems Scale score (Pyramidal System)
Parkinson's Disease	Diagnosis confirmation from a neurologist or specialist physician, otherwise the diagnostic motor signs and symptoms to be provided
Rheumatoid arthritis	1. Diagnosis confirmation from a rheumatologist, paediatrician or specialist physician 2. Alternatively, supporting pathology report (CRP/ESR and Rheumatoid Factor) to be provided and clinical history confirming diagnosis, as well as treatment history
Schizophrenia	Diagnosis confirmation from a psychiatrist
Systemic Lupus Erythematosus	Diagnosis confirmation from a specialist physician or rheumatologist
Ulcerative Colitis	Diagnosis to be confirmed by a gastroenterologist, specialist physician or surgeon

Clinical entry criteria for additional chronic conditions (plus, comprehensive & traditional plans)

Condition	Clinical Entry Criteria (please include the ICD10 code)
Acne	Diagnosis to be confirmed by a dermatologist
Allergic Rhinitis	Diagnosis to be confirmed by an ENT, paediatrician or specialist physician unless there is associated asthma
Ankylosing Spondylitis	Diagnosis to be confirmed by a rheumatologist or specialist physician
Anxiety Disorder (chronic)	No specific criteria required apart from ICD10 code
Arrhythmia/Dysrhythmia (non-PMB)	Diagnosis to be confirmed by a cardiologist or specialist physician
Atopic Dermatitis (Eczema)	Diagnosis to be confirmed by a dermatologist or paediatrician
Benign Prostatic Hyperplasia	No specific criteria except for ICD10-code for alpha blockers. For 5- α -reductase inhibitors, the prostate size in grams or millilitres is required
Cystic Fibrosis	Diagnosis to be confirmed by a pulmonologist, paediatrician or specialist physician
Gastro-oesophageal reflux disorder (GORD)	No specific information required apart from ICD-10 code for standard dose PPI up to 3 months, or for ongoing low dose PPI; FOLLOW UP scope report or gastroenterologist motivation required for standard dose PPI beyond 3 months and in all cases of double dose PPI
Gout	No specific criteria apart from ICD10 code
Hyperkinesis (Attention Deficit Hyperactivity Disorder)	Diagnosis to be confirmed by a paediatrician, neurologist or psychiatrist unless the prescriber is certified with a special qualification in ADHD (certification required)
Hypoparathyroidism	Laboratory results required
Hyperthyroidism	Diagnostic thyroid function results are required (TSH and T4)
Major depression	No specific criteria required apart from ICD10 code for antidepressants. A letter of motivation is required for any non-antidepressants (e.g., mood stabilisers and antipsychotics)
Menopause	Accepted from any prescriber for patients between the ages of 40 and 69 without cardiovascular comorbidities. Laboratory reports are required for confirmation of premature menopause
Motor Neuron Disease	Diagnosis to be confirmed by a neurologist or specialist physician

Myasthenia Gravis	Diagnosis to be confirmed by a neurologist or specialist physician
Osteoarthritis	No specific criteria apart from ICD10 code
Osteoporosis	DEXA scan to be supplied; in the case of fractures, an X-ray report is also required
Paget's Disease	Diagnosis to be confirmed by a neurologist or specialist physician
Peptic Ulcer	No specific information required apart from ICD-10 code for standard dose PPI up to 3 months, or for ongoing low dose PPI; FOLLOW UP scope report or gastroenterologist motivation required for standard dose PPI beyond 3 months and in all cases of double dose PPI
Psoriasis	Diagnosis to be confirmed by a dermatologist
Schizo-affective Disorder	Diagnosis to be confirmed by a psychiatrist
Spinal cord injuries (paraplegia/quadriplegia)	Diagnosis to be confirmed by a neurologist, neurosurgeon or specialist physician. All relevant reports (including scans) to be submitted.
Stroke	Date of event required
Transient Ischaemic Attack	Date of event required
Urinary incontinence	No specific criteria apart from ICD10 code

Clinical entry criteria for additional chronic conditions (plus and comprehensive only)

Condition	Clinical Entry Criteria (please include the ICD10 code)
Alzheimer's Disease	1. Diagnosis to be confirmed by a neurologist or psychiatrist 2. Baseline Folstein MMSE score is required 3. CT scan report to be supplied (if available) 4. Laboratory test results confirming the exclusion of other causes of dementia to be supplied (e.g., vitamin B12)
Meniere's Disease	Diagnosis to be confirmed by an ENT or neurologist

Clinical entry criteria for additional chronic conditions (all plans)

Condition	Clinical Entry Criteria (please include the ICD10 code) Nephrotic
Nephrotic Syndrome	Diagnosis to be confirmed by a nephrologist. All supporting diagnostic investigations (including urine analysis and histology if applicable) to be submitted
Pulmonary Embolism	Date of event required as well as clinical risk factors for recurrence

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

* 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				

Additional information/motivation

PLEASE NOTE: All chronic medication is subject to the Scheme Reference Price. 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

Section F: Prescribed Minimum Benefits

To be completed by the 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	<input type="checkbox"/>	Crohn's Disease	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Diabetes Insipidus	<input type="checkbox"/>	Hypothyroidism	<input type="checkbox"/>
Bipolar Mood Disorder	<input type="checkbox"/>	Diabetes Mellitus Type I	<input type="checkbox"/>	Multiple sclerosis	<input type="checkbox"/>
Bronchiectasis	<input type="checkbox"/>	Diabetes Mellitus Type II	<input type="checkbox"/>	Parkinson's Disease	<input type="checkbox"/>
Cardiac Failure	<input type="checkbox"/>	Dysrhythmias	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>
Cardiomyopathy Disease	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Schizophrenia	<input type="checkbox"/>
Chronic Obstructive Pulmonary Disorder	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Systemic Lupus Erythematosus	<input type="checkbox"/>
Chronic Renal Disease	<input type="checkbox"/>	Haemophilia	<input type="checkbox"/>	Ulcerative colitis	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	Hyperlipidaemia	<input type="checkbox"/>		

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
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