Chronic Illness Benefit application form 2020

This application form is to apply for the Chronic Illness Benefit and is only valid for 2020

MALCOR MEDICAL AID SCHEME
Administered by Discovery Health

Contact details
Tel: 0860 100 698 • PO Box 8012, Greenstone 1616 • www.malcormedicalaid.co.za

The latest version of the application form is available on www.malcormedicalaid.co.za. Alternatively members can phone 0860 100 698 and health professionals can phone 0860 44 55 66.

Who we are

The Malcor Medical Aid Scheme (referred to as 'the Scheme'), registration number 1547. This 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). We take care of the administration of your membership for the Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. You (the member) must complete and sign Section 1 of this form.
3. Your doctor must complete Section 2, other relevant sections, sign section 9 and attach any test results, clinical reports or other information that we need to review the request. These requirements are shown in Sections 3 and 4.
4. Please fax this completed application form and all supporting documents to **011 539 7000**, email it to **CIB_APP_FORMS@malcormedicalaid.co.za** or post it to **Malcor, CIB Department, PO Box 8012, Greenstone, 1616** .

1. Patient's details

Name and surname

ID or Date of birth

Membership number

Telephone

Fax

Cellphone

Email address

The outcome of this application must be sent to me by ☐ Email ☐ Fax

I give consent to Discovery Health (Pty) Ltd and Malcor Medical Aid Scheme to use the above communication channel for all future communication.

Patient's signature (if patient is a minor, main member to sign)

Date D D - M M - Y Y Y Y

MALCIB001

Member's acceptance and permission

I give permission for my healthcare provider to provide Malcor Medical Aid Scheme and Discovery Health (Pty) Ltd with my diagnosis and other relevant clinical information required to review my application. 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 make informed funding decisions.

I understand that:
1.1. Funding from the Chronic Illness Benefit is subject to meeting benefit entry criteria requirements as determined by Malcor Medical Aid Scheme.
1.2. The Chronic Illness Benefit provides cover for disease-modifying therapy only, which means that not all medicines for a listed condition are automatically covered by the Chronic Illness Benefit.
1.3. By registering for the Chronic Illness 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.
1.4. Funding for medicine from the Chronic Illness Benefit will only be effective from when Malcor Medical Aid Scheme receives an application form that is completed in full. Please refer to the table in Sections 3 and 4 to see what additional information is required to be submitted for the condition for which you are applying.
1.5. An application form needs to be completed when applying for a new chronic condition.
1.6. If you are approved on the benefit, you need to let us know when your treating doctor changes your treatment plan so that we can update your chronic authorisation/s. You can do this by e-mailing the new prescription to us or asking your doctor or pharmacist to do this for you. Alternatively, your doctor can log onto Health ID to make the changes, provided that you have given consent. If you do not let us know about changes to your treatment plan, we may not pay your claims from the correct benefit.
1.7 To make sure that we pay your claims from the correct benefit, we need the claims from your healthcare providers to be submitted with the relevant ICD-10 diagnosis code(s). Please ask your doctor to include your ICD-10 diagnosis code(s) on the claims they submit and on the form that they complete when they refer you to the pathologists and/or radiologists for tests. This will enable the pathologists and radiologists to include the relevant ICD-10 diagnosis code(s) on the claims they submit, ensuring that we pay your claims from the correct benefit.

I give the Scheme and the administrator consent to have access to and process all information (including general, personal, medical or clinical information) that is relevant to this application. I understand that this information will be used for the purposes of applying for and assessing my funding request for Chronic Illness Benefits. I consent to the Scheme and the administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical information) to my healthcare provider and to relevant third parties, to administer the Chronic Illness Benefits as well as undertake managed care
interventions related to the chronic condition.

2. Doctor's details

Name and surname

Practice Number

Speciality

Telephone Fax

Email

The outcome of this application must be sent to me by Email Fax

3. The Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions covered on Malcor Plan A, Malcor Plan B and Malcor Plan C.

Malcor Medical Aid Scheme covers the following Prescribed Minimum Benefit Chronic Disease List conditions, in line with legislation. Your cover is subject to benefit entry criteria. Approval on the Chronic Illness Benefit for your PMB CDL condition(s) offers cover for medicine and treatment baskets for the management of your condition(s). Please refer to the website for more information on what is covered on the benefit and how it is covered.

Chronic disease list condition	Benefit entry criteria requirements
Addison's disease	Application form must be completed by a paediatrician (in the case of a child), endocrinologist or specialist physician
Asthma	None
Bipolar mood disorder	Application form must be completed by a psychiatrist
Bronchiectasis	Application form must be completed by a paediatrician (in the case of a child), pulmonologist or specialist physician
Cardiac failure	None
Cardiomyopathy	None
Chronic obstructive pulmonary disease (COPD)	1. Please attach a lung function test (LFT) report that includes the FEV1/FVC post bronchodilator use 2. Please provide additional information when applying for oxygen including: a. arterial blood gas report off oxygen therapy b. number of hours of oxygen use per day
Chronic renal disease	1. Application form must be completed by a nephrologist or specialist physician 2. Please attach a diagnosing laboratory report reflecting creatinine clearance
Coronary artery disease	None
Crohn's disease	Application form must be completed by a paediatrician (in the case of a child), gastroenterologist, specialist physician or surgeon
Diabetes insipidus	Application form must be completed by an endocrinologist
Diabetes type 1	None
Diabetes type 2	Section 8 of this application form must be completed by the doctor
Dysrhythmia	None
Epilepsy	Application form for newly diagnosed patients must be completed by a neurologist, specialist physician or paediatrician (in the case of a child)
Glaucoma	Application form must be completed by an ophthalmologist
Haemophilia	Please attach the diagnosing laboratory report reflecting factor VIII or IX levels
HIV and AIDS (antiretroviral therapy)	Please do not complete this application form for cover for HIV and AIDS. To enrol or request information on our HIVCare programme, please call 0860 100 698
Hyperlipidaemia	Section 6 of this application form must be completed by the doctor
Hypertension	Section 5 of this application form must be completed by the doctor
Hypothyroidism	Section 7 of this application form must be completed by the doctor
Multiple sclerosis (MS)	1. Application form must be completed by a neurologist 2. Please attach a report from a neurologist for applications for beta interferon indicating: a. Relapsing – remitting history b. All MRI reports c. Extended disability status score (EDSS)
Parkinson's disease	Application form must be completed by a neurologist or specialist physician
Rheumatoid arthritis	Application form must be completed by a rheumatologist, paediatrician (in the case of a child) or specialist physician
Schizophrenia	Application form must be completed by a psychiatrist
Systemic lupus erythematosus	Application form must be completed by a paediatrician (in the case of a child), rheumatologist, nephrologist, pulmonologist or specialist physician
Ulcerative colitis	Application form must be completed by a paediatrician (in the case of a child), gastroenterologist, specialist physician or surgeon

4. The Additional Disease List (ADL) conditions covered on Malcor Plan A

If you are on Malcor plan A, you have cover for all the chronic conditions in the Additional Disease List below. Your cover is subject to benefit entry criteria. Approval on the Chronic Illness Benefit for your ADL condition(s) offers cover for medicine for the management of your condition(s). Please refer to the website for more information on how medicine is covered on the benefit.

Additional disease list condition	Benefit entry criteria requirements
Acne	Applications for Isotretinoin must be completed by a dermatologist
Allergic rhinitis	None
Ankylosing spondylitis	Application form must be completed by a rheumatologist or specialist physician
Arthritis	Application form must include a fully detailed medical report
Attention deficit and hyperactivity disorder (ADHD)	Application form must be completed by a psychiatrist, neurologist or paediatrician (in the case of a child).
Barret's oesophagus	Application form must be completed by a gastroenterologist, general surgeon or paediatrician (in the case of a child)
Chronic hepatitis	None
Cystic fibrosis	Application form must be completed by a pulmonologist, paediatrician (in the case of a child) or specialist physician
Depression	Applications for first line therapy will be accepted from GPs for 6 months only. Application from a psychiatrist will be required for further cover
Gastro-oesophageal reflux disease	Application form must be accompanied by a gastroscopy report substantiating the need for long term maintenance therapy
Motor neurone disease	None
Myasthenia gravis	None
Narcolepsy	Application form must be completed by a specialist
Obsessive compulsive disorder	Application form must be completed by a psychiatrist
Osteoarthritis	None
Osteoporosis	1. All applications must be accompanied by a DEXA bone mineral density scan (BMD) report 2. Application form must be completed by an endocrinologist for patients <50 years of age 3. Please attach information on additional risk factors in patient, where applicable 4. Please indicate if the patient sustained an osteoporotic fracture
Paget's disease	Application form must be completed by a specialist physician or paediatrician (in the case of a child)
Psoriasis	Application form must be completed by a dermatologist
Psoriatic arthritis	Application form must be completed by a rheumatologist or specialist physician

5. Application for hypertension (to be completed by doctor)

If the patient meets the requirements listed in either A, B or C below, hypertension will be approved for funding from the Chronic Illness Benefit.

A. Previously diagnosed patients

Was the diagnosis made more than six (6) months ago and has the patient been on treatment for at least that period of time? Yes ☐

B. Please indicate if your patient has any of these conditions

Chronic renal disease	☐	TIA	☐
Hypertensive retinopathy	☐	Coronary artery disease	☐
Prior CABG	☐	Myocardial infarction	☐
Peripheral arterial disease	☐	Pre-eclampsia	☐
Stroke	☐		

C. Newly diagnosed patients

Diagnosis made within the last six (6) months.

Blood pressure ≥ 130/85 mmHg and patient has diabetes or congestive cardiac failure or cardiomyopathy Yes ☐

OR

Blood pressure ≥ 160/100 mmHg Yes ☐

OR

Blood pressure ≥ 140/90 mmHg on two or more occasions, despite lifestyle modification for at least six months Yes ☐

OR

Blood pressure ≥ 130/85 mmHg and the patient has target organ damage indicated by Yes ☐

- Left ventricular hypertrophy or
- Microalbuminuria or
- Elevated creatinine

6. Application for hyperlipidaemia (to be completed by doctor)

If the patient meets the requirements listed in either A, B or C or E below, hyperlipidaemia will be approved for funding from the Chronic Illness Benefit. Information provided in section D will be reviewed on an individual basis.

A. Primary prevention

Please **attach the diagnosing lipogram**

Please supply the patient's current blood pressure reading _____ / _____ mmHg

Is the patient a smoker or has the patient ever been a smoker? Yes ☐ No ☐

Please use the Framingham 10-year risk assessment chart to determine the absolute 10-year risk of a coronary event (2012 South Africa Dyslipidaemia Guideline)

Does the patient have a risk of 20% or greater Yes ☐

OR

Is the risk 30% or greater when extrapolated to age 60 Yes ☐

B. Familial hyperlipidaemia

Please attach the diagnosing lipogram

Was the patient diagnosed with homozygous familial hyperlipidaemia and was the diagnosis confirmed by an endocrinologist or lipidologist? Yes ☐

Please attach supporting documentation.

OR

Was the patient diagnosed with heterozygous familial hyperlipidaemia and was the diagnosis confirmed by a specialist? Yes ☐

Please attach supporting documentation.

C. Secondary prevention

Please indicate what your patient has:

- Diabetes type 2 ☐
- Stroke ☐
- TIA ☐
- Coronary artery disease ☐
- Solid organ transplant. Please supply the relevant clinical information in Section D. ☐
- Chronic kidney disease. Please supply the diagnosing laboratory report reflecting creatinine clearance ☐
- Peripheral arterial disease. Please supply the Doppler ultrasound or angiogram. ☐
- Diabetes type 1 with microalbuminuria or proteinuria ☐
- Any vasculitides where there is associated renal disease. Please supply the diagnosing laboratory report reflecting creatinine clearance ☐

D. Please supply any other relevant clinical information about this patient that supports the diagnosis of hyperlipidaemia.

E. Was the patient diagnosed with hyperlipidaemia more than five years ago and the laboratory results are not available? Yes ☐

7. Application for hypothyroidism (to be completed by doctor)

Should the patient meet the requirements listed in either A, B, C, D or E below, hypothyroidism will be approved for funding from the Chronic Illness Benefit.

A. Thyroidectomy. Please indicate whether your patient has had a thyroidectomy Yes ☐

B. Radioactive iodine. Please indicate whether your patient has been treated with radioactive iodine Yes ☐

C. Hashimoto's thyroiditis. Please indicate whether your patient has been diagnosed with Hashimoto's thyroiditis Yes ☐

D. Please attach the initial or diagnostic laboratory results that confirm the diagnosis of hypothyroidism, including TSH and T4 levels

Was the diagnosis based on the presence of **clinical symptoms and one of the following:**

A raised TSH and reduced T4 level Yes ☐

OR

A raised TSH but normal T4 level and higher than normal thyroid antibodies Yes ☐

OR

A raised TSH level of greater than or equal to 10 mIU/l on two or more occasions at least three months apart in a patient with a normal T4 level Yes ☐

E. Was the patient diagnosed with hypothyroidism more than five years ago and the laboratory results are not available? Yes ☐

8. Application for diabetes type 2 (to be completed by doctor)

If the patient meets the requirements listed in either A, B or C below, diabetes type 2 will be approved for funding from the Chronic Illness Benefit.

A. Please attach the initial or diagnostic laboratory results that confirm the diagnosis of diabetes type 2.
Please note that finger prick and point of care tests are not accepted for registration on the Chronic Illness Benefit.

Do these results show:

A fasting plasma glucose concentration ≥ 7.0 mmol/l — Yes ☐

OR

A random plasma glucose ≥ 11.1 mmol/l — Yes ☐

OR

A two hour post-load glucose ≥ 11.1 mmol/l during an oral glucose tolerance test (OGTT) — Yes ☐

OR

An HbA1C ≥ 6.5% — Yes ☐

B. Is the patient a type 2 diabetic on insulin? — Yes ☐

C. Was the patient diagnosed with diabetes type 2 more than five years ago and the laboratory results are not available? — Yes ☐

Important: please note that no exceptions will be made for patients being treated with Metformin monotherapy.

9. Medicine required (to be completed by doctor)

To assist us in paying claims for the diagnosis of condition(s) from the correct benefits, please ensure that you include the **Date when the condition was first diagnosed** in the table below.

ICD-10 Code	Condition description	Date when condition was first diagnosed	Medicine name, strength and dosage	How long has this patient used this medicine?	
				Years	Months

Notes to doctors

9.1 Please ensure that the relevant ICD-10 diagnosis code(s) are used when you submit your claims to the Scheme to ensure payment from the correct benefit.

9.2 Please include the ICD-10 diagnosis code(s) when referring your patient to the pathologists and/or radiologists. This will enable the pathologists and radiologists to include this information on their claims and allow us to comply with legislation by paying Prescribed Minimum Benefits (PMB) claims correctly.

9.3 We will approve funding for generic medicine, where available, unless you have indicated otherwise.

9.4 Please submit all the requested supporting documents with this application to prevent delays in the review process.

9.5 Should you make changes to your patient's treatment plan, you need to let us know so that we can update their chronic authorisation/s. You can do this by e-mailing the new prescription to us or by logging onto Health ID to make the changes, provided that the patient has given consent. If you or your patient do not let us know about changes to the treatment plan, we may not pay claims from the correct benefit.

Doctor's signature

Date D D - M M - Y Y Y Y