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Chronic Medicine Benefit Application Form

IMPORTANT NOTE: This form must be completed by the treating doctor. For a list of approved conditions, please see Section E. Attach the prescription and supporting documentation (laboratory results or motivation), if necessary, to the application. Fax the documents to 0866 764 374 or email pcauth@mediscor.co.za

A Dispensing Provider:

Please select where the member would like to collect their medication.

- ◯ Dispensing GP
- ◯ Prime Cure Network Pharmacy
  Find a Prime Cure Network povider at www.primecure.co.za
- ◯ Medipost (Courier Pharmacy) Practice Number: 6065732

B Doctor Details:

Referring Doctor: _____ Practice Number: _____

Email: _____ Tel: _____

Fax: _____ Cell: _____

C Details of Principal Member/Policyholder:

Surname: _____ First Name: _____

Email: _____ Member/Policy Number: _____

Medical Scheme/Health Insurer: _____

Medical Scheme/Health Insurer Plan/Option: _____

D Patient Details:

Surname: _____ First Name: _____

Postal Address: _____ Postal Code: _____

Tel: _____ Fax: _____ Cell: _____

Email: _____ Dependant Code: _____

Identity Number/Passport: _____ Gender: ◯ Male ◯ Female Age: _____

E CDL Chronic Conditions:

Make a selection

- ◯ Addison's Disease
- ◯ Asthma
- ◯ Bipolar Mood Disorder
- ◯ Bronchiectasis
- ◯ Cardiac Failure
- ◯ Cardiomyopathy
- ◯ (COPD) Chronic Obstructive Pulmonary Disease
- ◯ Chronic Renal Disease
- ◯ Coronary Artery Disease
- ◯ Crohn's Disease
- ◯ Diabetes Insipidus
- ◯ Diabetes Mellitus Type I
- ◯ Diabetes Mellitus Type II
- ◯ Dysrhythmia
- ◯ Epilepsy
- ◯ Glaucoma
- ◯ Haemophilia
- ◯ Hyperlipidaemia
- ◯ Hypertension
- ◯ Multiple Sclerosis (MS)
- ◯ Parkinson's Disease
- ◯ Rheumatoid Arthritis
- ◯ Schizophrenia
- ◯ Systematic Lupus Erythematosus
- ◯ Ulcerative Colitis

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F Patient's Medical Information:

Include copies of the results or reports, both diagnosing and latest where necessary, to prevent delays in the review of this application

Weight: _____ kg Height: _____ cm BMI: _____ Smoker: ◯ Yes ◯ No Cigarettes per day: _____

Waist Circumference: _____ cm Allergies: _____

Blood Pressure Reading: _____ Date Measured: _____

Glucose:

Random Blood Glucose: _____ Date Measured: _____

Glucose Tolerance Test (GTT): _____ Date Measured: _____

Fasting Blood Glucose: _____ Date Measured: _____

HbA1c: _____ Date Measured: _____

Lipogram:

Total Cholesterol: _____ HDL: _____

LDL: _____ Triglyceride: _____

Kidney Function:

Creatinine Clearance: _____ Date Measured: _____

Microalbuminuria: _____ Date Measured: _____

Lung Function:

FEV1: _____ FEV/FEC: _____

Indicate if the patient has the following

◯ Ischaemic Heart Disease/Myocardial Infarction Date: _____

◯ Peripheral Vascular Disease Date: _____

◯ Atherosclerosis Date: _____

◯ Transient Ischaemic Attack/Stroke Date: _____

First degree relative with premature heart disease:

◯ Female < 65 Years ◯ Male < 55 Years

G Chronic Medication:

Prescribe according to the Prime Cure medicine formulary and chronic disease list. Only Medication on the formulary will be covered.
The formulary is available for lookup on www.primecure.co.za

Chronic Condition (eg: Hypertension)	ICD-10 Code (eg: J10)	Date of Initial Diagnosis (eg: 01/01/2018)	Medicine Name, Strength & Dosage	No of Repeats (If not Ongoing)	How long has the Patient used this Medicine?	
					Months	Years

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H Clinical Motivation/Additional Comments:

Doctor Signature: _____ Application Date: _____

I Member/Policyholder Consent:

I, _____ (full name) Identity number _____ consent to the sharing of my clinical information pertaining to my Chronic Medicine Benefit application, and the management thereof with Prime Cure. I also consent to Prime Cure sharing my clinical information with any other healthcare professional involved in the management of my condition, including hospital risk management professionals appointed by the Medical Scheme/Health Insurer or the Scheme's administrator, provided that this information will not be made available to my employer(s) or any other person not involved in my healthcare, or case management, without my express written consent. I acknowledge that whilst Prime Cure shall use its best endeavours to uphold the confidentiality of all information disclosed to it, Prime Cure shall not be held liable for any claims by me or my dependents arising from any unintentional unauthorised disclosure of my personal information, my medical information pertaining to my health condition and the treatment and management thereof to a third party; or as a result of Prime Cure having to use ICD-10 codes when filing a claim for payment with the Medical Scheme/Health Insurer.

Member/ Policyholder Signature: _____ Application Date: _____