ANGLOVAAL GROUP MEDICAL SCHEME

Administered by Discovery Health

Contact details
Tel: 0860 100 693 • PO Box 652509, Benmore 2010 • www.avgms.co.za

Chronic Illness Benefit application form 2019

This application form is to apply for the Chronic Illness Benefit and is only valid for 2019

The latest version of the application form is available on www.avgms.co.za. Alternatively members can phone 0860 100 693 and health professionals can phone 0860 44 55 66.

Who we are

Anglovaal Group Medical Scheme (referred to as 'the Scheme'), registration number 1571. 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 and fill in your details on the top of each page 4, 5, 6 and 7.
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 the completed application form and all supporting documents to 011 539 7000, email it to **CIB_APP_FORMS@discovery.co.za** or post it to Anglovaal Group Medical Scheme, CIB Department, PO Box 652919, Benmore, 2010

1. Patient's details

Name and surname

ID/Date of birth

Membership number

Telephone

Fax

Cellphone

Email

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

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

Member's acceptance and permission

I give permission for my healthcare provider to provide Anglovaal Group Medical 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 Anglovaal Group Medical 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 Anglovaal Group Medical 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 Payment for completion of this form, on submission of a claim, is subject to Anglovaal Group Medical Scheme rules and where I am a valid and active member at the service date of the claim.

I consent to Anglovaal Group Medical Scheme and Discovery Health (Pty) Ltd disclosing, from time to time, information supplied to Anglovaal Group Medical Scheme and Discovery Health (Pty) Ltd (including general or medical information that is relevant to my application) to my healthcare provider, to administer my Chronic Illness Benefit. I agree that Anglovaal Group Medical Scheme and Discovery Health (Pty) Ltd may disclose this information at its discretion, but only as long as all the parties involved have agreed to keep the information confidential.

Patient's signature

(if patient is a minor, main member/legal guardian to sign)

Date Y Y Y Y M M D D

2. Doctor's details

Name and surname

BHF practice number

Specialty

Telephone

Fax

Email

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 Anglovaal Group Medical Scheme

Anglovaal Group Medical Scheme covers the following Prescribed Minimum Benefit Chronic Disease List conditions in line with legislation.

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 attach a motivation 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 HIV*Care* programme, please call 0860 100 693
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 Anglovaal Group Medical Scheme

Your cover is subject to benefit entry criteria.

Additional disease list condition	Benefit entry criteria requirements
Allergic rhinitis	None
Alzheimer's disease	Application form must be completed by a psychiatrist, neurologist or specialist physician
Ankylosing spondylitis	Application form must be completed by a rheumatologist or specialist physician
Cystic fibrosis	Application form must be completed by a pulmonologist, paediatrician (in the case of a child) or specialist physician
Gout	None
Major depression	Applications for 1st line therapy will be accepted from GPs for 6 months only. Psychiatrist motivation is required for further cover
Motor neurone disease	None
Myasthenia gravis	None
Osteoarthritis	None
Osteoporosis	1. All applications must be accompanied by a DEXA bone mineral density scan (BMD) report 2. Endocrinologist motivation required for patients <50 years 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

Patient's name and surname

Membership number

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 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	☐	Angina	☐
Prior CABG	☐	Myocardial infarction	☐
Peripheral arterial disease	☐	Pre-eclampsia	☐
Stroke	☐		

C. Newly diagnosed patients

Diagnosis made within the last six 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 6 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

Patient's name and surname

Membership number

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

If the patient meets the requirements listed in either A, B, 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 ☐

Patient's name and surname

Membership number

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

If the patient meets 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 $\geq$ 7.0 mmol/l Yes ☐

OR

A random plasma glucose $\geq$ 11.1 mmol/l Yes ☐

OR

A two hour post-load glucose $\geq$ 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.

Patient's name and surname

Membership number

9. Medicine required (to be completed by doctor)

Formulary medicine will be funded up to the Scheme Rate for Medicine. There will be no co-payment for medicine selected from the formulary.

For non-formulary medicine, we fund up to the Chronic Drug Amount (CDA), which is a monthly amount we pay up to, for a specific medicine class. The member may be liable for a co-payment where the cost of the medicine is greater than the CDA.

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

Notes to doctors

9.1 The doctor's fee for completion of this form will be reimbursed on code 0199, on submission of a separate claim. Payment of the claim is subject to Anglovaal Group Medical Scheme rules and where the member is a valid and active member at the service date of the claim.

9.2 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 funding for multiple chronic conditons were applied for, then it would be appropriate to list all the relevant ICD-10 codes.

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 An application form only needs to be completed when applying for a **new chronic condition**. You can email a prescription for changes to your patient's treatment plan for an approved condition. You can also complete and submit an application form for a new condition as well as make changes to your patient's treatment plan through Health ID, provided that your patient has given consent.

Doctor's signature

Date Y Y Y Y M M D D