SIZWE HOSMED
MEDICAL SCHEME
Your choice for quality care

0860 103 455
086 608 0771
chronic@sizwehosmed.co.za
Waterfall Office Park,
1 Bekker Rd, Vorna Valley,
Midrand
1696

CHRONIC MEDICINE PROGRAMME APPLICATION

HOW TO COMPLETE THIS FORM

NOTE: It is important that this form is completed in full, incomplete forms **WILL NOT** be processed and may cause a delay in members receiving their medication.

- The patient or principal member must complete section 1 in full, incomplete forms will **NOT** be processed.
- Section 2-4 must be fully completed by the doctor to ensure efficient processing.
- Completed forms may be faxed or e-mailed to: chronic@sizwehosmed.co.za.

SECTION 1 — TO BE COMPLETED BY PATIENT OR PRINCIPAL MEMBER

MEMBER'S DETAILS

Select Plan: Essential Copper ☐ | Access Core ☐ | Access Saver ☐ | Gold Ascend ☐ | Gold Ascend EDO ☐ | Value Platinum ☐ | Value Platinum Core ☐ | Titanium Executive ☐

Membership No.:					
Surname:		Title:		Initials:	

PATIENT'S DETAILS

(as per ID) First Name (s):					
Surname:		Title:		Initials:	
Date of birth	D D M M Y Y Y Y				

Address:					
				Postal Code:	
Tel (work):		Cell:			
Tel (home):					
Email:					

I hereby give permission for my doctor to provide Sizwe Hosmed Medical Scheme with my diagnosis and other relevant clinical information required to review my application. I understand that funding from chronic benefit is subject to clinical criteria and drug utilisation review as determined by Sizwe Hosmed Medical Scheme. By registering on the programme, I accept that due to my chronic condition I may be subject to wellness management interventions and periodic review and that this may include access to my medical records. Generic medication or therapeutic alternatives can significantly reduce prescription costs, while still providing the desired therapeutic effect. Should a suitable generic equivalent be available, Sizwe Hosmed Medical Scheme will only reimburse to the value of these alternatives.

NOTE: Treatment for Prescribed Minimum Benefit (PMB) conditions will be approved in accordance with Sizwe Hosmed Medical Scheme formularies

Member's Signature _____

Date D D M M Y Y Y Y

BROKER DETAILS:

Brokerage Name:	
(as per ID) Full Name & Surname of Broker:	
Tel:	
Email:	

Member initials _____

16502|SH | CP | 220926

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SECTION 2 GENERAL INFORMATION (TO BE COMPLETED BY DOCTOR)

Weight (kg): ,	Height (m): ,	BMI: ,	
Is the patient post-menopausal (female)?	☐ Yes	☐ No	
Smoking status:	☐ Smoker	☐ Ex-smoker	☐ Non-smoker
Liquor intake:	☐ Daily	☐ Weekly	☐ Occasionally
Exercise:	☐ Not really	☐ > 3 hours per week	

Allergies (specify):	
Details of hospital admission in the past year:	

SECTION 3 TO BE COMPLETED BY TREATING PROVIDER

NOTE: Please attach appropriate diagnostic tests that were performed to confirm the chronic illness(es) that the patient suffers from, e.g. Pathology results, bone density reports, ECG reports, criteria for rheumatoid arthritis.

Diabetes Mellitus: Initial venous glucose result:		HBA1C result:	
Hypertension			
Average blood pressure reading (mmHg):		Latest blood pressure reading (mmHg):	
Hyperlipidaemia Please attach INITIAL lipogram report			
Please specify family or personal history of Cardiovascular disease			
Chronic renal failure Creatinine clearance result:			
Please attach other relevant pathology reports for the use of erythropoetin or iron replacement.			
Glaucoma Intra-ocular pressure reading:	☐ Left	☐ Right	
PEF (L/min):		FEB (L):	
Use of bronchodilator per day:	☐ Times	Limitations on daily activities:	☐ Yes ☐ No
Using home oxygen:	☐ Yes	☐ No	
Schizophrenia Please include DSM IV criteria			

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SECTION 4 TO BE COMPLETED BY TREATING PROVIDER

ICD-10 Code (diagnosis)	Medication name strength and dosage	Date initiated	Previous medication and reason for changes
		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	

Surname:		Initials:		Practice number:	
Specialty:					

ACKNOWLEDGEMENT BY EXAMINING DOCTOR

I hereby certify that the particulars hereto are - to the best of my knowledge - true and accurate, having conducted a personal examination and/or procured the tests and/or other diagnostic investigations referred to.

Doctor's signature

D D M M Y Y Y Y

Date

SECTION 5 SCHEME DECLARATION

As Sizwe Hosmed Medical Scheme we are strongly committed to protecting your personal data. We are required by POPIA to explain why and how we collect, use, and disclose your personal information, which may include health and financial information. Sizwe Hosmed Medical Scheme will keep your information supplied to us in this application confidential. Acceptance of these terms and conditions is a requirement for activation and servicing of your medical scheme membership. You give us consent to process your personal information for the following purposes:

a. Administration of your health care option;
b. Provision of managed care services to you;
c. Providing relevant information to a contracted third party;
d. To profile and analyse risk;
e. For research purposes and;
f. To comply with legislation. To comply with legislation.

Please note that we will only share your information with a third party if you have granted us your consent for the disclosure of the information to such third party or if a contractual relationship exists in terms of which we are obliged to provide your information to such third-party. We may amend this notice from time to time, please check our website to inform yourself of any changes.

Member initials _____

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