DAY1 HEALTH
FSP Number 11319

DAY1 HEALTH CHRONIC MEDICATION BENEFIT APPLICATION FORM

Please complete this application form as follows:

The member of the plan must fill in all personal and membership details in Section 1 & 2.

Please make sure you complete both the sections in full, in order to effectively process your application.The doctor must fill in all medical information required in Section 3 & 4 of the application form.

PLEASE FAX OR EMAIL YOUR APPLICATION TO:

Fax: 086 246 9253
Email: chronic@1doctor.co.za

SECTION 1: PRINCIPAL MEMBER INFORMATION.

Surname							Initals	
Title	Prof	Dr	Mr	Mrs	Miss	Ms	Mast	Identity Number
Date of Birth	d d	m m	y y				Membership Number	
Medical Aid Plan							Option 1	
Employer								
Where would you like your medicine delivered?								
							Code	
E-Mail Address								
Tel No Home							Work	
Cell								

SECTION 2: IMPORTANT PATIENT INFORMATION.

Surname (if different)		Title	Prof	Dr	Mr	Mrs	Miss	Ms	Mast
First Names									

Date of Birth	d	d	m	m	y	y	Identity Number													

Tel No Home												Work											
Cell																							

Relationship to Member												Gender	M	F	Dependant Code		

Mass (kg)				Height (cm)				Do you smoke?	Y	N	If yes, how many cigarettes a day?		

How long have you smoked for?	d	d	m	m	y	y	Do you consume alcohol?	Y	N	If Yes, state type, quantity and frequency	

If you have any chronic medication queries, please contact the Day1 Health Chronic Helpdesk at 0876 100 600.

Funding from the Chronic Medication Benefit is subject to clinical entry criteria, the medication acquisition rules and formulary determined by Day1 Health (Pty) Ltd and agreed to by the scheme.

Please Note: DAY1 HEALTH (PTY) LTD adopts a medication reimbursement policy adhering to the single exit pricing structure for all generic and brand name medication. This policy will be implemented at all points of service across all benefit plans and no exception shall be made except where prior authorisation has been obtained from DAY1 HEALTH (PTY) LTD. Should "non-preferred" medication be required to treat an approved chronic condition, your GP is required to give motivation for this medication via our Medication Appeals Procedure. Medication not pre-authorised as chronic by DAY1 HEALTH (PTY) LTD may be eligible for reimbursement from the Chronic Medication Benefit.

I hereby give permission for the GP to state my diagnoses and other relevant clinical information on this form.
By applying for the Chronic Medication Benefit, I agree that my condition may be subject to disease management interventions.

Signed Principal

Member Patient (unless a Minor)

Date

SECTION 3: RULES APPLICABLE TO CHRONIC MEDICATION BENEFIT (CMB)

1. All personal and medical details must be submitted accurately by the GP and the patient where specifically requested.
2. Certain chronic conditions require additional clinical information to be submitted with this application form. Following Drug Utilisation Review, additional clinical information may also be requested.

Cardiovascular Diseases:

Chronic Diagnosis		ICD-10 Code	Clinical / Laboratory Supporting Documentation
Cardiac Failure			
Cardiomyopathy			
Coronary Artery Disease			
Dysrhythmias			
Hypertension			*BP Reading*
Hyperlipidaemia			

Additional Information - Hyperlipidaemia														
Exercise	Y	N	*BP Reading*											
Smoking	Y	N	*If yes, how may cigarettes a day?*											
Lipogram Reading (Initial/Diagnostic)				Date of Lipogram:	d	d	m	m	y	y				
TCL:		LDL:		HDL:		Triglycerides:								

Risk Factors: (Please indicate where applicable)					
Angina/Myocardial Infarction		Angioplasty/Stent		Cerebrovascular Accident (CVA)	
Family History		Peripheral Vascular Disease		Transient Ischaemic Attack	

Endocrine System:

Chronic Diagnosis		ICD-10 Code	Clinical / Laboratory Supporting Documentation
Addison's Disease			
Diabetes Insipidus			
Diabetes Mellitus 1			
Diabetes Mellitus 2			
Hypothyroidism			

Additional Information - Diabetes Mellitus 1 or 2										
Fasting Glucose:		Date:	d	d	m	m	y	y		
Glucose tolerance test:		Date:	d	d	m	m	y			

Respiratory Diseases:

Chronic Diagnosis		ICD-10 Code	Clinical / Laboratory Supporting Documentation					
Asthma								
Bronchiectasis								
Chronic Obstructive Pulmonary Disease (COPD)			Stage 1		Stage 2		Stage 3	
			Initial FEV 1 (spirometry report):					

Auto Immune Diseases:

Chronic Diagnosis		ICD-10 Code	Clinical / Laboratory Supporting Documentation
Multiple Sclerosis*			*Please Note that confirmation of diagnosis by MRI scan is required from a Neurologist. *Neurologist Practice Number:*
Systemic Lupus Erythematosus			
Rheumatoid Arthritis*			*Please Note that confirmation of diagnosis by MRI scan is required from a Neurologist. *Neurologist Practice Number:*

Gastrointestinal Diseases:

Chronic Diagnosis		ICD-10 Code	Clinical / Laboratory Supporting Documentation
Chron's Disease*			
Ulcerative Colitis			

Neurological Diseases:

Chronic Diagnosis		ICD-10 Code	Clinical / Laboratory Supporting Documentation
Epilepsy			
Parkinson's Disease			

Ophthalmological Diseases:

Chronic Diagnosis		ICD-10 Code	Clinical / Laboratory Supporting Documentation
Glaucoma			

Other Diseases:

Chronic Diagnosis		ICD-10 Code	Clinical / Laboratory Supporting Documentation
Chronic Renal Disease*			Glomerular Filtration rate/Creatinine clearance
HIV			CD4 count

3. All DAY1HEALTH (PTY) LTD rules and exclusions will be applied during te review and authorisation of requested chronic medication in respect of any chronic illness.
4. Only approved General Practitioners within DAY1 HEALTH (PTY) LTD's Provider Network may apply for chronic medication benefits on behalf of DAY1 HEALTH (PTY) LTD members on the contracted benefit plans.
5. All approved chronic medication may only be obtained from a dispensary within the Medication Distribution Network authorised by All DAY1 HEALTH (PTY) LTD.
6. General Exclusions from **Chronic Medication Benefit (C.M.B)** include these commonly requested medicines: Exclusions as detailed in the General Practitioner Provider Manual.
7. Access to any medication through the C.M.B is subject to Clinical Entry Criteria and Drug Utilisation Review.
8. Diseases marked with * will exclude biological medication.

SECTION 4: CURRENT MEDICATION REQUIRED

Diagnosis	Medication Name, Strength and Dosage	Monthly Quantity	Duration on Medication		Repeats
			Years	Months	

Are any of the above Diagnoses related to injury on duty?	Y	N
If yes, please state:		

Date of injury								d	d	m	m	y	y	
Injury on Duty (IOD) Number:														

MEDICATION HISTORY IF DIFFERENT FROM CURRENT			
Year	Diagnosis	Medication and Strength	Duration of use

Patient Allergies:		
State any other illnesses the patient suffers from:		
May current medication be substituted with a generic if appropriate?	Y	N

SECTION 5: DOCTOR'S DETAILS

Name																																							

Practice Postal Address																																							
																														Code								

Practice Physical Address?																																							
																														Code								

Tel No												Fax No																		
Speciality												E-mail Address																		
BHF Practice No												HPC SA REG No																		

Doctor's Signature		Date	d	d	m	m	y	y