Contact us
Tel: 0860 103 933, PO Box 652509, Benmore, 2010, www.lahealth.co.za

Chronic Illness Benefit application form 2010

for LA KeyPlus, LA Focus and LA Active members only

This application form is to apply for the Chronic Illness Benefit and is only valid for 2010.

The latest version of the application form is available on www.lahealth.co.za. Alternatively members can phone 0860 103 933 and health professionals can phone 0860 44 55 66.

Fax the completed application form to (011) 539 7000, email it to CIB_APP_FORMS@discovery.co.za or post it to Discovery Health, CIB Department, PO Box 652919, Benmore, 2010.

What you must do

Please go through these steps:

Step 1: Fill in and sign the application form (section 1), and fill in your details on the top of page 3 and 4.

Step 2: Take the application form to your doctor.

The scheme has the right to change the rules for membership from time to time. You may ask us for a copy of them at any time. When you sign this application, you confirm that you have read and understood the rules and that you agree that you and those you apply for will be bound by them.

If you have any questions, please let us or your broker know. Once we have assessed your application, we will let you know.

1. Important patient information (to be completed by the member)

Title Surname

First names

Sex M F Identity number Member number

Telephone Home Work

Cellphone Fax

Email address

The outcome of this application must be communicated to me via my email address Yes ☐ No ☐ or Fax number Yes ☐ No ☐

I give permission for my doctor to provide Discovery Health (the Administrator)/LA Health (the Scheme) with my diagnosis and other relevant clinical information required to review my application for the Chronic Illness Benefit. I understand that

1. funding from the Chronic Illness Benefit is subject to clinical entry criteria and drug utilisation review as determined by LA Health
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
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. I understand that not doing this may lead to the withdrawal of this benefit
4. medicine approved by the Chronic Illness Benefit will only be effective from when LA Health receives an application form that is completed in full
5. the covered Chronic Illness Benefit conditions and clinical entry criteria may change from time to time and I may need to send an updated or new application form if the Chronic Illness Benefit department asks for this.

By signing this, I also give my consent that Discovery Health/LA Health may, from time to time, disclose any information supplied to Discovery Health – including general or medical information – to my broker or any other third party. I agree that LA Health may disclose this information at its sole discretion, but only as long as all the parties involved have agreed to keep the information confidential at all times.

Signed principal member

Patient (unless a minor)

93435 02/10

2. The Prescribed Minimum Benefits (PMB) (for members on all Benefit Options)

For information only. Do not fax this page to LA Health. LA Health covers the following Prescribed Minimum Benefit conditions, in line with legislation on all Benefit Options.

PMB condition	Clinical Entry Criteria (CEC) requirements
Addison's disease	Application form must be completed by a paediatrician or endocrinologist.
Asthma	The South African Treatment Guidelines for Asthma, as published in the SAMJ are applied to all applications.
Bipolar Mood Disorder	Application form must be completed by a psychiatrist.
Bronchiectasis	Application form must be completed by a paediatrician or pulmonologist.
Cardiac failure	None
Cardiomyopathy	None
Chronic obstructive pulmonary disease (COPD)	1. Please attach a lung function test (LFT) report which includes the FEV1/FVC and FEV1 post bronchodilator use. 2. Please attach a motivation from a specialist when applying for oxygen including: a. oxygen saturation levels off oxygen therapy b. number of hours of oxygen use per day
Chronic renal disease	1. Application form must be completed by a nephrologist. 2. Please attach a diagnosing laboratory report reflecting creatinine clearance.
Coronary artery disease	Please provide details of history of previous cardiovascular disease or event(s) in patient, if applicable.
Crohn's disease	1. Application form must be completed by a gastroenterologist. 2. This application form is not applicable for biologics (eg Revellex®, Enbrel®, Humira®, Mabthera®). Call 0860 103 933 to request the relevant application form, which must be completed by a gastroenterologist. Biologics are not covered on LA KeyPlus.
Diabetes insipidus	Application form must be completed by an endocrinologist.
Diabetes Type 1	None
Diabetes Type 2	Refer to Section 5
Dysrhythmias	None
Epilepsy	Application form 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 a 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 100 417.
Hyperlipidaemia	Section 4 must be completed by the doctor.
Hypertension	Section 3 must be completed by the doctor.
Hypothyroidism	1. Please attach the initial or diagnostic laboratory report that confirms the diagnosis of hypothyroidism, including TSH and T4 blood levels. 2. Please indicate if the patient had a thyroidectomy.
Hypoparathyroidism*	Application form must be completed by an endocrinologist or paediatrician (in the case of a child).
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)
Organ transplantation*	Application must be completed by a specialist.
Paraplegia*	None
Parkinson's disease	Application form must be completed by a neurologist.
Pemphigus*	Application must be completed by a dermatologist or paediatrician.
Peripheral arteriosclerotic disease*	Application must be completed by a cardiologist or neurologist.
Pituitary disorders*	Application form must be completed by an endocrinologist, neurologist or paediatrician (in the case of a child). Cover includes, but is not limited to, the following conditions: Cushing's disease, acromegaly and hyperprolactinaemia.
Quadriplegia*	None
Rheumatoid arthritis	1. Application must be completed by a rheumatologist, specialist physician or paediatrician (in the case of a child). 2. Application for COXIBs must be accompanied by a motivation for its use over conventional anti-inflammatories. 3. This application form is not applicable for applications for biologics (eg Revellex®, Enbrel®, Humira®, Mabthera®). Call 0860 103 933 to request the relevant application form which must be completed by a rheumatologist. Not covered on LA KeyPlus. Biologics are not covered on LA KeyPlus.
Schizophrenia	Application form must be completed by a psychiatrist.
Stroke*	Applications for clopidogrel (Plavix) must be accompanied by a motivation from a neurologist for use over aspirin therapy.
Systemic lupus erythematosus	Application form must be completed by a rheumatologist or nephrologist.
Thrombocytopaenia purpura*	Application must be completed by a specialist.
Ulcerative colitis	1. Application form must be completed by a gastroenterologist. 2. This application form is not applicable for biologics (eg Revellex®, Enbrel®, Humira®, Mabthera®). Call 0860 9103 933 to request the relevant application form which must be completed by a gastroenterologist. Not covered on LA KeyPlus. Biologics are not covered on LA KeyPlus.
Valvular heart disease*	Application must be completed by a cardiologist.

* These conditions are within diagnostic or treatment pairs of the Prescribed Minimum Benefit conditions and are available across all Benefit Options and payable as prescribed in Regulation 8.

Patient name and surname | | | | | | | | | | | | | | | Membership number | | | | | | | | | | | | | |

3. Application for hypertension (to be completed by the doctor)

- This section must be completed for all patients applying for hypertension.
- A specialist must complete this section for patients with hypertension who are younger than 30 years of age. This is in line with the South African Treatment Guidelines for Hypertension.

1. Patient weight in kg | | | | Patient height in metres | | | |
2. When did this patient commence drug therapy for hypertension? Y Y Y Y M M D D
3. For hypertension **diagnosed in the last six months and all newly diagnosed patients** please supply two initial blood pressure readings (before drug therapy commenced) done at least two weeks apart in order to determine the stage of hypertension.

   i) _____/_____ mmHg Date Y Y Y Y M M D D

   ii) _____ mmHg Date Y Y Y Y M M D D

4. Current BP reading (for all patients) _____/_____ mmHg

Does the patient have target organ damage or any of the associated conditions as listed below. Tick relevant conditions below.

Left ventricular hypertrophy	☐	Stroke/TIA	☐	Hypertensive retinopathy	☐
Angina	☐	Chronic renal disease	☐	Prior CABG (Coronary artery bypass graft)	☐
Myocardial infarction	☐	Peripheral arterial disease	☐	Heart failure	☐

4. Application for hyperlipidaemia (to be completed by the doctor)

Primary hyperlipidaemia

Please attach diagnosing lipogram.

LA Health will fund medicine for patients with an absolute 10 year risk of a coronary event of 20% or more. This is in line with the Council for Medical Scheme's Algorithm.

1. Patient weight in kg | | | | Patient height in metres | | | |
2. Does the patient smoke? Yes ☐ No ☐
3. Family history (Please complete the table below for primary and familial hyperlipidaemia)

	Father	Mother	Brother	Sister
Treatment or event details				
Age at time of diagnosis or event				

4. Current BP reading (for all patients) _____/_____ mmHg

Please note: The following questions need to be answered for the application to be processed for primary hyperlipidaemia

Have secondary causes been excluded? Yes ☐ No ☐

Please supply the following results:

a) Hypothyroidism	TSH:
b) Diabetes mellitus	Fasting glucose:
c) Alcohol excess (where applicable)	gamma-GT:
d) Drug induced dyslipidaemia?	Yes ☐ No ☐

Familial hyperlipidaemia

Please attach the diagnosing lipogram. Please complete the family history table above (4.3)

Please indicate any signs of familial hyperlipidaemia in this patient

Secondary prevention

Please indicate what condition(s) your patient has:

Type I diabetes with microalbuminuria (please submit supporting clinical reports) ☐

Any of the vasculitides eg SLE where there is associated renal disease ☐

Type II diabetes ☐	Intermittent claudication ☐	Nephrotic syndrome and chronic renal failure ☐
Prior CABG ☐	Stroke/TIA ☐	Ischaemic heart disease ☐

Patient name and surname | Membership number

5. Application for Diabetes type 2

1. Please attach a laboratory report that confirms the diagnosis of type 2 diabetes.
2. The Chronic Illness Benefit will fund medicine for type 2 diabetes if the criteria for the diagnosis of this condition are met based on the SEMDSA Guidelines.
3. The specific criteria are:
   - Fasting plasma glucose concentration ≥ 7.0 mmol/l
   - Random plasma glucose ≥ 11.1 mmol/l
   - Two hour post-glucose ≥ 11.1 mmol/l during an Oral Glucose Tolerance Test (OGTT)
4. Please note that based on cost and clinical guidelines, applications for glitazones and nateglinide require a motivation for use over conventional therapy from a specialist physician or endocrinologist.

6. Current medicine required (to be completed by the doctor)

Note to member and doctor: The Chronic Illness Benefit application requirements (ie tests, motivations, supporting documentation or completion by a specialist) are indicated in Section 2 and 3 of this application form. Please read and submit the documentation relevant to the condition you are applying for.

ICD-10	Diagnosis description	Date when condition was first diagnosed	Medicine name, strength and dosage	How long has the patient used this medicine?		May a generic be used	
				Years	Months	Yes	No

8. Doctor's details and signature (to be completed by the doctor)

Name

BHF Practice number

Telephone Work | Fax

Email

Speciality _____

Doctor's signature _____ Date Y Y Y Y M M D D

The outcome of this application must be communicated to me via my email address Yes ☐ No ☐ **OR** fax number Yes ☐ No ☐

Note to doctors:

- **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 from the Medical Savings Account (if applicable to the member's Benefit Option), subject to Scheme Rules and availability of funds.**
- 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 multiple chronic conditions were applied for, then it would be appropriate to list all the relevant ICD-10 codes.
- You may call 0860 103 933 for **changes** to your patient's medicine for an **approved** condition. An application form only needs to be completed when applying for a **new chronic condition.**