ENGEN Medical Benefit Fund

Administered by Discovery Health

**Contact details**

Tel: 0800 001 615 • PO Box 652509, Benmore 2010 • www.engenmed.co.za

# Chronic Illness Benefit application form

**This application form is to apply for the Chronic Illness Benefit and is only valid for 2020**

**The latest version of the application form is available on www.engenmed.co.za. Alternatively members can phone 0800 001 615 and health professionals can phone 0860 44 55 66.**

### Who we are

Engen Medical Benefit Fund (referred to as 'EMBF'), registration number 1572, is a non-profit organisation, registered with the Council for Medical Schemes.
Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the administrator') is a separate company, an authorised financial services provider and is responsible for the administration of your membership on behalf of the Fund.

### 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.
3. Take the application form to your doctor to 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@engenmed.co.za** or post it to Engen Medical Benefit Fund, CIB Department, PO Box 652509, Benmore, 2010.

## 1. Patient's details

Name and surname

Date of birth / ID number

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 Engen Medical Benefit Fund to use the above communication channel for all future communication.

Patient's signature

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

Date D D M M Y Y Y Y

## 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 ☐

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**Member's acceptance and permission**

I give permission for my healthcare provider to provide EMBF 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:

2.1 Funding from the Chronic Illness Benefit is subject to meeting benefit entry criteria requirements as determined by EMBF.

2.2 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.

2.3 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.

2.4 Funding for medicine from the Chronic Illness Benefit will only be effective from when EMBF 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.

2.5 An application form needs to be completed when applying for a new chronic condition.

2.6 If you are approved on the benefit, you need to let us know when your treating doctor changes your treatment plan so that we can update your chronic authorisation/s. You can do this by e-mailing the new prescription to us or asking your doctor or pharmacist to do this for you. Alternatively, your doctor can log onto Health ID to make the changes, provided that you have given consent. If you do not let us know about changes to your treatment plan, we may not pay your claims from the correct benefit.

2.7 To make sure that we pay your claims from the correct benefit, we need the claims from your healthcare providers to be submitted with the relevant ICD-10 diagnosis code(s). Please ask your doctor to include your ICD-10 diagnosis code(s) on the claims they submit and on the form that they complete when they refer you to the pathologists and/or radiologists for tests. This will enable the pathologists and radiologists to include the relevant ICD-10 diagnosis code(s) on the claims they submit, ensuring that we pay your claims from the correct benefit.

I give EMBF and the administrator consent to have access to and process all information (including general, personal, medical or clinical information) that is relevant to this application. I understand that this information will be used for the purposes of applying for and assessing my funding request for Chronic Illness Benefits. I consent to the Scheme and the administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical information) to my healthcare provider and to relevant third parties, to administer the Chronic Illness Benefits as well as undertake managed care interventions related to the chronic condition.



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## 3. The Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions covered on EMBF

EMBF covers the following Prescribed Minimum Benefit Chronic Disease List conditions in line with legislation. Your cover is subject to benefit entry criteria. Approval on the Chronic Illness Benefit for your PMB CDL condition(s) offers cover for medicine and treatment baskets for the management of your condition(s). Please refer to the website for more information on what is covered on the benefit and how it is covered.

| Chronic disease list condition | Benefit entry criteria requirement |
|---|---|
| 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<br>2. Please provide additional information when applying for oxygen including:<br>a. arterial blood gas report off oxygen therapy<br>b. number of hours of oxygen use per day |
| Chronic renal disease | 1. Application form must be completed by a nephrologist or specialist physician<br>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 HIVCare programme, please call 0800 001 615 |
| 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<br>2. Please attach a report from a neurologist for applications for beta interferon including:<br>a. Relapsing – remitting history<br>b. All MRI reports<br>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 EMBF

If you have claimed chronic medicine for 3 or more consecutive months, please fill out section 9 of this application form detailing the condition and medicine details. Please note that your cover is subject to benefit entry criteria. Approval on the Chronic Illness Benefit for your ADL condition(s) offers cover for medicine for the management of your condition(s). Please refer to the website for more information on how medicine is covered on the benefit.



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## 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 (6) 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 | ☐ | Coronary artery disease | ☐ |
| Peripheral arterial disease | ☐ | Myocardial infarction | ☐ |
| Prior CABG | ☐ | Pre-eclampsia | ☐ |
| Stroke | ☐ | | |

### C. Newly diagnosed patients

Diagnosis made within the last six (6) 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 six (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

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Please note that this form expires on 31/03/2021. Up to date forms are available on www.engenmed.co.za.

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## 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 documentation.

### C. Secondary prevention

**Please indicate if your patient has any of these conditions:**

- 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 ☐

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## 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 if your patient has had a Thyroidectomy — Yes ☐

**B. Radioactive iodine** Please indicate if your patient has been treated with radioactive iodine — Yes ☐

**C. Hashimoto's thyroiditis** Please indicate if 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 ≥ 7.0 mmol/l — Yes ☐

OR

A random plasma glucose ≥ 11.1 mmol/l — Yes ☐

OR

A two hour post-load glucose ≥ 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.



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## 9. Medicine required (to be completed by doctor)

To assist us in paying claims for the diagnosis of condition(s) from the correct benefits, please ensure that you include the **Date when the condition was first diagnosed** in the table below.

| ICD-10 Code | Condition description | Date when condition was first diagnosed | Medicine name, strength and dosage | How long has this patient used this medicine? | |
|---|---|---|---|---|---|
| | | | | Years | Months |
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**Notes to doctors**

9.1. Please ensure that the relevant ICD-10 diagnosis code(s) are used when you submit your claims to EMBF to ensure payment from the correct benefit.

9.2. Please include the ICD-10 diagnosis code(s) when referring your patient to the pathologists and/or radiologists. This will enable the pathologists and radiologists to include this information on their claims and allow us to comply with legislation by paying Prescribed Minimum Benefits (PMB) claims correctly.

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. Should you make changes to your patient's treatment plan, you need to let us know so that we can update their chronic authorisation/s. You can do this by e-mailing the new prescription to us or by logging onto Health ID to make the changes, provided that the patient has given consent. If you or your patient do not let us know about changes to the treatment plan, we may not pay claims from the correct benefit.

Doctor's signature ____________________

Date D D M M Y Y Y Y