ENGEN Medical Benefit Fund

Administered by Discovery Health

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

Bariatric surgery application form

This form is to apply for funding for bariatric surgery. It must be completed by an accredited surgeon from an accredited centre of excellence who will be performing the surgery. The member must complete sections 3, 4 and 6 of this form.
The turnaround time on receipt of a completed form is seven working days. We may require an additional three days should we need to forward the request to an external advisory panel before reaching a funding decision.

Who we are

Engen Medical Benefit Fund (referred to as 'theFund'), registration number 1572, is a not-for-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 and 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. To avoid administration delays, please ensure this application is completed in full.
3. Send the completed and signed form with the required clinical information and patient consent to us via email at **MOTIVATIONS@engenmed.co.za**

1. Referring healthcare professional details (must be a surgeon, physician or endocrinologist)

Special name

Speciality

Specialist BHF number

Specialist HPCSA registration number

Telephone

Fax

Email

Doctor's signature

Date D D M M Y Y Y Y

Name of facility where the procedure will be done

BHF number of the facility where the procedure will be done

2. Details of the surgeon performing the procedure (if it differs from section 1)

Surgeon name

Specialist BHF number

Specialist HPCSA registration number

Telephone

Fax

Email

Doctor's signature

Date D D M M Y Y Y Y

3. Principal member information

Title

Initials

Surname

First name/s (as per identity document)

Date of birth D D M M Y Y Y Y

ID or passport Number

Membership number

EMBBA001

Please note that this form expires on 31/03/2023. Up to date forms are available on www.engenmed.co.za.

Option type

Postal Address

Code

Telephone (H) (W)

Cellphone Fax

4. Patient information

Title Initials Surname

First name Gender M F

Race African Coloured Indian / Asian White Other

This information is required by the Council for Medical Scheme for statistical purposes. You are not compelled to provide this information.

Do not want to disclose Date of birth D D M M Y Y Y Y

Telephone (H) (W)

Cellphone Fax

Email

May we communicate your confidential information using the email address provided? Yes No

May we communicate your confidential information using the fax number provided? Yes No

5. Clinical history

1. Current weight in kilograms (kg)
2. Height in centimetres (cm)
3. Waist circumference in centimetres (cm)
4. Body Mass Index (BMI)
5. Blood pressure Systolic/Diastolic /
6. Body fat % % (only for patients <150kg)

Co-morbid illnesses

1. Diabetes mellitus
2. Hypertension
3. Dyslipidaemia
5. Coronary artery disease
6. Other (specify)

Please note: Attach script for the treatment of the above co-morbidities

What is the proposed surgical procedure?

Type of bariatric surgery:
- Roux-en-Y
- Bilopancreatic diversion (BPD)
- Gastric sleeve
- Gastric band

Please attach the following to this application form

1. Report from endocrinologist/physician
2. Report from bariatric surgeon

EMBBA001

3. Report from clinical psychologist/psychiatrist

4. Copy of blood results (e.g. fasting glucose, lipogram, TSH, ALT/GGT, CRP etc.)

5. Copy of gastroscopy report

6. Report from biokineticist/physiotherapist (where applicable)

7. Sleep apnoea studies (where applicable)

8. Dietician report

9. Supporting documentation from an anaesthetist verifying that the patient is medically fit to undergo an anaesthetic procedure

6. Consent to collection of data for outcomes measurement and registry requirements

I, _____ (patient's name in full), hereby give Engen Medical Benefit Fund and Discovery Health (Pty) Ltd consent to the collection of all medical/clinical information pertaining to my application for _____ (name of medication/procedure/test) for the treatment of _____ (name of condition) as requested either from myself or my consulting doctor, _____ (doctor's name in full). In addition, I specifically consent to Engen Medical Benefit Fund and Discovery Health (Pty) Ltd having access to my clinical records at my doctor's rooms for the purposes of conducting clinical audits. The information will be used for the purposes of measuring clinical outcomes and developing a registry that will allow Engen Medical Benefit Fund to make informed funding decisions. The confidential nature of the information Engen Medical Benefit Fund and Discovery Health (Pty) Ltd receives will be respected at all times. I understand that approval for funding for this treatment is conditional upon my cooperation with all aspects of this pre-assessment.

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