

IMPORTANT NOTE: To be completed by General Practitioner. Only complete this form for CHRONIC medication for any CDL condition(s) (see section E). Attach the prescription and supporting documentation (laboratory results or motivation), if necessary, to the application. Fax the documents to 0866 764 374 or email pcauth@mediscor.co.za

A Dispensing Provider

The following documents are required to be provided for your refund request to be processed.

- Dispensing GP
- Network Pharmacy
- Medipost (Courier Pharmacy) Practice Number: 6065732

B Doctor Details

Referring Doctor: Practice Number:

Email:

Tel: Fax: Cell:

C Details of Principal Member

Surname:

First Name:

Email:

Member Number: Medical Scheme: Option:

Employer: Paypoint No:

D Patient Details

Surname:

First Name:

Postal Address: Code:

Email: Dependant Code:

Tel: Fax: Cell:

Identity Number/Passport: Gender: Male Female Age

E CDL Chronic Conditions

Indicate by means of a CROSS (X)

<input type="radio"/> Addison's Disease	<input type="radio"/> (COPD) Chronic Ostructive Pulmonary Disease	<input type="radio"/> Diabetes Mellitus Type I	<input type="radio"/> Hyperlipidaemia	<input type="radio"/> Scizophrenia
<input type="radio"/> Asthma	<input type="radio"/> Chronic Renal Disease	<input type="radio"/> Diabetes Mellitus Type II	<input type="radio"/> Hypertension	<input type="radio"/> Systematic Lupus Erymatosus
<input type="radio"/> Bipolar Mood Disorder	<input type="radio"/> Coronary Artery Disease	<input type="radio"/> Dysrhythmias	<input type="radio"/> Hypothyroidism	<input type="radio"/> Ulcerative Colitus
<input type="radio"/> Bronchiectasis	<input type="radio"/> Crohn's Disease	<input type="radio"/> Epilepsy	<input type="radio"/> Multiple Sclerosis (MS)	<input type="radio"/> Chronic Depression
<input type="radio"/> Cardiac Failure	<input type="radio"/> Diabetes Insipidus	<input type="radio"/> Glaucoma	<input type="radio"/> Parkinson's Disease	<input type="radio"/> Gout
<input type="radio"/> Cardiomyopathy	<input type="radio"/> HRT	<input type="radio"/> Haemophilia	<input type="radio"/> Rheumatoid Arthritis	
<input type="radio"/> Other:	<input type="text"/>			

F Patient's Medical Information

Include copies of the results or reports, both diagnosing and latest where necessary, to prevent delays in the review of this application

Weight: kg Height: cm BMI: Smoker: Yes No Cigarettes per day:

Waist Circumference: cm Allergies:

Blood Pressure Reading: Date Taken: - -

Glucose: Date Taken: - -

Random: Fasting:

GTT: HbA1c:

Lipogram: Date Taken: - -

Total Cholesterol: HDL:

LDL: Triglyceride:

Creatinine Clearance: Date Taken: - -

Microalbuminuria: Date Taken: - -

Lung Function: Date Taken: - -

FEV1: FEV/FEC:

Indicate if the patient has the following:

Ischaemic Heart Disease/MI Date: - - Arteriosclerosis Date: - -

Peripheral Vascular Disease Date: - - TIA/Stroke Date: - -

First degree relative with premature heart disease:

Female < 65 Years Male < 55 Years

G Chronic Medication Application

Prescribe according to the Prime Cure medicine formulary and chronic disease list. Only Medication on the formulary will be covered. The formulary is available for lookup on www.primecure.co.za

Chronic Condition (eg: Hypertension)	ICD 10 Code (eg: J10)	Date of Initial Diag- nosis (eg: 01/01/2018)	Medicine Name, Strength & Dosage	No of Repeats (If not Ongoing)	How long has the Patient used this Medicine?	
					Months	Years

H Clinical Motivation / Additional Comments

Doctor Signature:

Application Date: - -