primecure
healthcare management

CDL Chronic Application Form

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/Policyholder:

Surname: ____

First Name: ____

Email: ____

Member/Policy Number: ____

Medical Scheme/Health Insurer: ____ Medical Scheme/Health Insurer Plan: ____

Employer: ____ Paypoint No: ____

D Patient Details:

Surname: ____

First Name: ____

Postal Address: ____ Code: ____

Email: ____ Dependant Code: ____

Tel: ____ Fax: ____ Cell: ____

IIdentity Number/Passport: ____ Gender: Male ○ Female ○ Age ____

E CDL Chronic Conditions:

Indicate by means of a CROSS (X)

○ Addison's Disease	○ Chronic Depression	○ Diabetes Mellitus Type I	○ Haemophilia	○ Parkinson's Disease
○ Asthma	○ (COPD) Chronic Obstructive Pulmonary Disease	○ Diabetes Mellitus Type II	○ HRT	○ Rheumatoid Arthritis
○ Bipolar Mood Disorder	○ Chronic Renal Disease	○ Dysrhythmias	○ Hyperlipidaemia	○ Schizophrenia
○ Bronchiectasis	○ Coronary Artery Disease	○ Epilepsy	○ Hypertension	○ Systematic Lupus Erythematosus
○ Cardiac Failure	○ Crohn's Disease	○ Glaucoma	○ Hypothyroidism	○ Ulcerative Colitis
○ Cardiomyopathy	○ Diabetes Insipidus	○ Gout	○ Multiple Sclerosis (MS)	

○ Other: ____

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: y y y y - m m - d d

Glucose: Date Taken: y y y y - m m - d d

Random: [ ] Fasting: [ ]

GTT: [ ] HbA1c: [ ]

Lipogram: Date Taken: y y y y - m m - d d

Total Cholesterol: [ ] HDL: [ ]

LDL: [ ] Triglyceride: [ ]

Creatinine Clearance: [ ] Date Taken: y y y y - m m - d d

Microalbuminuria: [ ] Date Taken: y y y y - m m - d d

Lung Function: Date Taken: y y y y - m m - d d

FEV1: [ ] FEV/FEC: [ ]

Indicate if the patient has the following:

◯ Ischaemic Heart Disease/MI Date: y y y y - m m - d d ◯ Arteriosclerosis Date: y y y y - m m - d d

◯ Peripheral Vascular Disease Date: y y y y - m m - d d ◯ TIA/Stroke Date: y y y y - m m - d d

First degree relative with premature heart disease:

◯ Female < 65 Years ◯ Male < 55 Years

G Member/ Policyholder Consent:

I,______________________________ (full name) Identity number ____________________
consent to the health care workers responsible for my treatment and/or management in terms of the Programme providing the Programme's Case Managers with the clinical information pertaining to my chronic condition, and the treatment and management thereof. To the Programme's Case Managers sharing the above mentioned information with any other health care worker involved with my care or management (including hospital risk management professionals appointed by the Medical Scheme/Health Insurer or the Scheme's administrator) Provided that no clinical information regarding my health condition will be available to my employer(s) or any other person not involved in my health care, or case management, without my express written consent. Acknowledge that whilst Prime Cure shall use its best endeavors to uphold the confidentiality of all information disclosed to it. Prime Cure shall not be liable for any claims by me or my dependents arising from any unintentional unauthorized disclosure of my personal information, my medical information pertaining to my health condition and the treatment and management thereof to a third party; or as a result of Prime Cure having to use ICD 10 codes when filing a claim for payment with the Medical Scheme/Health Insurer.

Member/ Policyholder Signature: ____________________ Application Date: y y y y - m m - d d

H 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 Diagnosis (eg: 01/01/2018)	Medicine Name, Strength & Dosage	No of Repeats (If not Ongoing)	How long has the Patient used this Medicine?	
					Months	Years

I Clinical Motivation / Additional Comments:

Doctor Signature: ______________________ Application Date: y y y y - m m - d d

Address: 2nd Floor, The Oval - East Wing, Wanderers Office Park, 52 Corlett Drive, Illovo, 2196
Email: customerservice@primecure.co.za; Web: www.kaelo.co.za
Group Directors: J Jutzen
Non-Executive Directors: K Bouic, Z Omar
Reg. No. 1997 / 017429 / 07

kaelo