

ADVANCED ILLNESS / PALLIATIVE CARE APPLICATION FORM



The Advanced Illness Benefit (AIB) is available on all Bestmed options. The AIB gives Bestmed members who have an advanced-stage illness access to a full palliative care programme and is available for "end-of-life" home-based care and "in lieu of hospitalisation" home-based care subject to Bestmed Scheme Rules.

The AIB is funded at 100% Scheme tariff, with an annual benefit limit depending on your option. Pre-authorisation is required. Please send information and documents to adv.illness@bestmed.co.za

The AIB includes the following disciplines: palliative doctor / nursing agency / hospice home base visits, and social worker (if needed). This benefit excludes any medicine, feeding supplements, and equipment. All providers that will form part of the Palliative care team, practice numbers, tariff codes and quantity is needed.

This gives you Scheme-approved care in the comfort of your home. The AIB is our *Personally Yours* promise to be by your side, no matter where the journey leads.

1. MAIN MEMBER DETAILS

Title		Membership number	
Surname			
Full names			
ID number			
Physical address			Postal Code
Email address			
Telephone number		Cell phone number	

2. PATIENT DETAILS

Title		ID number	
Surname			
Full names			
Membership number		Dependant code	
Physical address			Postal Code
Email address			
Telephone number		Cell phone number	

Current residential location:

☐ Own home with spouse	☐ Residing with children
☐ Own home with carer	☐ Retirement village
☐ Own home living alone	☐

Membership number		Doctor's practice number	
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3. ADVANCED CARE PLANNING

Does the patient have an Advanced Care Plan and/or Living Will?

Yes

No

If "Yes" please supply the nominated third party's details or the proxy's details:

Title		ID number	
Surname			
Full names			
Relationship			
Email address			
Telephone number		Cell phone number	

By signing consent, I give my permission for the identified next-of-kin to be contacted in order for us to assist with the patient's healthcare needs. I understand that as the patient's condition changes, other care treatment plans may be introduced and I give permission for other multidisciplinary healthcare providers to be contacted.

Member / patient / third party / proxy's signature on behalf of the patient

Date

D	D	M	M	Y	Y	Y	Y
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4. ABOUT THE TREATING DOCTOR/S

1. Treating Doctor

Practice number

Practice number	
Surname	
Name	
Speciality	
Email address	
Telephone	
Cell phone number	
Physical address	
Postal Code	

2. Treating Doctor

Practice number

Practice number	
Surname	
Name	
Speciality	
Email address	
Telephone	
Cell phone number	
Physical address	
Postal Code	

Membership number

Doctor's practice number

5. CLINICAL SUMMARY FOR PATIENT WITH ADVANCED DISEASE

Date of assessment

D	D	M	M	Y	Y	Y	Y
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Date of disease diagnosis

D	D	M	M	Y	Y	Y	Y
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Have you and your patient discussed why you are applying for this benefit at this stage

Yes

No

ICD-10 code

Number of admissions in the past 6 months

Treatment intent

Palliative

☐

Curative

☐

End-of-life

☐

Is disease directed treatment ongoing?

Yes

No

If "Yes" provide the type of treatment.

		Treatment date from	Treatment date to
	Radiotherapy		
	Chemotherapy		

6. TO BE COMPLETED BY TREATING DOCTOR

Select the applicable

ECOG Performance status		✓
0	Fully active, able to carry on all pre-disease performance without restriction.	
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work.	
2	Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours.	
3	Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours.	
4	Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair.	
5	Dead	
Karnofsky Performance status		✓
100	Normal, no complaints, no evidence of disease.	
90	Able to carry on normal activity, minor signs or symptoms of disease.	
80	Normal activity with effort, some signs or symptoms of disease.	
70	Cares for self but unable to carry on normal activity or to do active work.	
60	Requires occasional assistance, but is able to care for most of his/her personal needs.	
50	Requires considerable assistance and frequent medical care.	
40	Disabled; requires special care and assistance.	
30	Severely disabled; hospital admission is indicated although death not imminent.	
20	Very ill; hospitalisation necessary and active supportive treatment necessary.	
10	Moribund	
0	Dead	

Lansky Scale (Recipient age ≥ 1 year and < 16 years)		✓
Able to carry on normal activity, no special care is needed		
100	Fully active.	
90	Minor restrictions in physically strenuous play.	
80	Restricted in strenuous play, tires more easily, otherwise active.	
Mild to moderate restriction		
70	Both greater restrictions of, and less time spent in active play.	
60	Ambulatory up to 50% of time, limited active play.	
50	Considerable assistance required for any active play, fully able to engage in quiet play.	
Moderate to severe restrictions		
40	Able to initiate quiet activities.	
30	Needs considerable assistance for quiet activity.	
20	Limited to very passive activity initiated by others (e.g. TV).	
10	Completely disabled, not even passive play.	

Membership number

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Doctor's practice number

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7. PALLIATIVE CARE PLAN

Medicine

NOTE: Medicine is not part of AIB. Please send your prescription to medicine@bestmed.co.za

Item	Dose	Frequency	Duration	Repeat

Other supportive treatment

Social worker		Please specify	
Counselling		Please specify	
Home nursing (excl. frail care)		Please specify	
Oxygen		Please specify	
Hospice		Please specify	
Referral to palliative care doctor		Please specify	

Other:

Additional notes:

Doctor's signature

Date

D	D	M	M	Y	Y	Y	Y
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Membership number

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Doctor's practice
number

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8. CONSENT PROVISIONS BY APPLICANT

1. I hereby expressly make the following acknowledgements in respect of Bestmed's processing of my Personal Information and/or Special Personal Information and/or that of my dependants / child(ren) / spouse(s) ("collectively referred to as "Personal Information"), as defined in terms of the Protection of Personal Information Act, 4 of 2013 (POPIA):
 - 1.1 That I have read and understood the provisions of Bestmed's Data Protection and Privacy Policy, thereby fully appreciating the manner in which Bestmed may process my Personal Information and for which purpose(s) Bestmed may process such Personal Information.
 - 1.2 That through submitting this application, I may be providing Bestmed with the Personal Information of my spouse(s), children and/or other dependant third parties.
 - 1.3 That by engaging with Bestmed through any physical and/or electronic means, Bestmed will in effect be processing the Personal Information provided by me from time to time.
 - 1.4 That Bestmed may from time to time, depending on the circumstances, collect my Personal Information from another source other than myself.
 - 1.5 That I fully appreciate that Bestmed places a high premium on my privacy and/or that of my dependants, spouse(s) and/or children.
 - 1.6 That I have read and understood the undertakings made by Bestmed in its Data Protection and Privacy Policy to the effect that it will ensure that any and all of my Personal Information and/or that of my dependants / child(ren) / spouse(s) shall be processed with a reasonable standard of care as may be expected from Bestmed.
 - 1.7 That I fully appreciate that Bestmed will only process my Personal Information and/or that of my dependants / child(ren) / spouse(s) in a manner consistent with the provisions of its Data Protection and Privacy Policy, as well as for the purpose(s) set forth therein.
 - 1.8 That, in accordance with the provisions of Section 18 of POPIA, I have been provided with adequate notification of the processing of my Personal Information by Bestmed, the scope and purpose(s) for such processing, as well as my rights to object to such processing should I elect to do so.
 - 1.9 That I acknowledge that the processing of my Personal Information is a mandatory requirement for the existence of a valid medical aid.
2. In light of the above acknowledgements, and in accordance with the requirements set forth in Section 11 of POPIA, I hereby provide my specific and informed consent to Bestmed for the processing of my Personal Information and/or that of my dependants / child(ren) / spouse(s), for any purpose(s) legitimately connected or related to my application for membership, which purpose(s) may include, but not be limited to the following:
 - 2.1 To provide or manage any information, products and/or services requested by me pursuant to my application for membership.
 - 2.2 To establish my needs, requirements and preferences in relation to the products and/or services provided by the Bestmed.
 - 2.3 To facilitate the delivery of products and/or services to me as a member of Bestmed.
 - 2.4 To administer my claims and premiums.
 - 2.5 To activate my medical aid and/or prescribed benefits.
 - 2.6 To allocate a unique identifier to me for the purpose of securely storing, retaining, and recalling my Personal Information from time to time, including after my membership is terminated.
 - 2.7 For general administration purposes pertaining to my membership.
 - 2.8 For legal and/or contractual purposes and to enable Bestmed to comply with its contractual obligations towards me.
 - 2.9 To transact with suppliers and business partners, including healthcare service providers, managed facilities, network hospitals, pharmacies and relevant regulatory authorities to facilitate the delivery of products and/or services to me.
 - 2.10 To provide me with health and wellness information throughout the subsistence of my membership.
 - 2.11 To transact with third parties and transfer my Personal Information to such third parties for the purpose of enabling Bestmed to fulfil its contractual obligations towards me.
 - 2.12 To analyse my Personal Information collected for research and statistical purposes.
 - 2.13 To transfer my Personal Information across the borders of South Africa to other jurisdictions should it be required in the legitimate pursuit of Bestmed's business requirements.
 - 2.14 To carry out analysis and profiling of my membership profile.
3. In as far as I provide Bestmed with the Personal Information of any third party, including my spouse(s), children or other dependants, I hereby warrant that I have acquired the consent of such third party to do so and in the event of that individual being a child, I do so in my capacity as a "competent person" in respect of such Personal Information, as contemplated in terms of the provisions of POPIA.

Accordingly, I hereby indemnify and hold Bestmed harmless against any claims of whatever nature that may arise as a result of the processing of any Personal Information as provided by myself, for purposes of my membership with Bestmed.

4. Aside from information which is legally required (such as tax certificates, vital benefit information and claims statements) Bestmed may also send me important information about Bestmed products and services - such as the Bestmed Newsletter and additional benefit information.

Yes	No
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Signature of applicant

Date

D	D	M	M	Y	Y	Y	Y
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Membership number

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Doctor's practice number

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