CHRONIC MEDICINE APPLICATION FORM

A. APPLICATION PROCESS

1. Complete one application form per patient.
2. The completed and signed application form can be e-mailed to medicine@bestmed.co.za, faxed to 012 472 6760 or posted to PO Box 2297, Pretoria, 0001.
3. Incomplete application forms will NOT be processed.
4. Registration of the medicine will only be given from the date on which Bestmed receives the fully completed application. No authorisations will be backdated.
5. If the medicine and/or dosage has changed, it is not necessary to complete an application form. Bestmed will only require a copy of the new prescription with the relevant ICD-10 code(s).
6. Certain conditions, may require additional information in order to extend the authorisation period.
7. Bestmed will cover the cost, at Scheme tariff, of the first application form completed. Thereafter, the cost of completing any additional forms will be paid from the available acute benefits/savings account, also at Scheme tariff.
8. **Note that Bestmed will require specific documentation related to the conditions in the table below. Please ensure that these criteria are followed in order to facilitate your request.**

If you have any enquiries, please contact Bestmed on 086 000 2378 (Monday to Friday - 08:00 to 17:00) or alternatively refer to the benefit brochure for more comprehensive details. The information is also available on our website at www.bestmed.co.za.

DISCLAIMER: Should a dispute arise with regard to any benefit, the registered Rules of Bestmed as approved by the Registrar of Medical Schemes shall prevail. A copy of the Scheme Rules may be requested at any time.

CONDITION	SPECIFIC REQUIREMENT
Addison's disease	Prescription required from endocrinologist or physician
Ankylosing spondylitis	Prescription required from a rheumatologist or physician
Anaemia	Most recent laboratory report required
Attention deficit disorder (ADD) attention deficit hyperactivity disorder (ADHD)	Prescription required from a psychiatrist, paediatrician or neurologist
Alzheimer's disease	Mini-mental state examination (MMSE) required together with a prescription
Autism	Prescription required from a paediatrician, paediatric neurologist or child psychiatrist
Blepharospasm	Prescription required from a neurologist together with a motivation
Bronchiectasis, cystic fibrosis and pulmonary interstitial fibrosis	Prescription required from a pulmonologist or physician, or a paediatrician (in the case of a child)
Collagen disease/scleroderma and Paget's disease	Prescription required from a physician
Crohn's disease and ulcerative colitis	Prescription required from a gastroenterologist or physician with motivation and supporting documentation
Chronic obstructive pulmonary disease (COPD)	Lung function test (LFT) report is required which includes the FEV1/FVC and FEV1 post bronchodilator use. When applying for oxygen authorisation, the following is required: For initial applications: a. A valid prescription b. Blood gas report including oxygen saturation For extension of authorisation: a. Compliance report (average daily oxygen usage)
Chronic renal disease	Application form must be completed by a nephrologist or physician. Attach supporting laboratory reports
Diabetes mellitus (Type 2)	Submit HbA1c blood test results and/or fasting blood glucose results, pre-treatment value and current values
Diabetes insipidus	Application form must be completed by an endocrinologist or physician
Epilepsy	EEG report must be submitted with the application or a prescription from the neurologist is required or a paediatrician (in the case of a child)

Haemophilia	Prescription required from a physician. For initial applications: attach a laboratory report reflecting factor VIII or IX levels For medicine fill release: dosing chart is required.
Hyperlipidaemia	Lipogram results required
Multiple sclerosis	Prescription required from a neurologist with supporting scans for initial applications. Attach a report from a neurologist for applications for beta interferon indicating: a. Relapsing – remitting history b. Extended disability status score (EDSS)
Osteoporosis	Most recent Bone Mineral Density (BMD) test results required
Polyarteritis nodosa/psoriatic arthritis and Sjögren's syndrome	Application form must be completed by a rheumatologist or physician
Psychiatric conditions	Prescription is required from a psychiatrist. A family practitioner may prescribe the following active ingredients: fluoxetine, citalopram, escitalopram and tricyclic anti-depressants
Rheumatoid arthritis	Prescription required from a rheumatologist. A family practitioner may also submit a prescription along with the pathology report

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Sections 1 to 3 must be completed by the member.

Sections 4 and 5 must be completed by a medical practitioner.

1. PARTICULARS OF PRINCIPAL MEMBER

Surname

First name

Membership number

Date of birth D D M M Y Y Y Y

2. PARTICULARS OF THE PATIENT

Surname

First name

Date of birth D D M M Y Y Y Y

Does the patient smoke? Yes No

Did the patient smoke in the past? Yes No

Hysterectomy Yes No

Height cm

Weight kg

Gender M F

Dependant code

3. PATIENT'S CONSENT

I irrevocably hereby grant permission on behalf of myself as well as on behalf of my dependant(s), if applicable, to any physician, person or party who may be in possession of or obtain information concerning my state of health or that of my dependant(s), treatment received or expected as well as any other relevant information to divulge such information to Bestmed or its proxy, on demand, also after my death or that of my dependant(s). I understand that this information together with other information will be used to manage my health or that of my dependant(s) and to evaluate the payment of benefits for certain medical conditions. I guarantee that I have obtained my dependant(s) consent to grant authorisation.

Signature of applicant

Date D D M M Y Y Y Y

PLEASE NOTE:

- Chronic benefits are granted according to the Bestmed formulary per condition per benefit option.
- The formularies are available on the Bestmed website at www.bestmed.co.za
- If non-formulary medicine does qualify for benefits, it will be subject to an additional co-payment.

IMPORTANT/BELANGRIK

Without the correct ICD-10 code(s), the application cannot be processed. If this is a first-time application and the patient was registered for chronic medication at the previous medical scheme, please submit a copy of the previous chronic authorisation letter.

4. MEDICINE BENEFITS APPLIED FOR

(Please list all the medicine that is used for a specific condition. This new authorisation will supersede all previous authorisations for the same condition.)

Patient name and surname __________ Membership number __________ Dependant code __________

ICD-10 CODE	NAME & STRENGTH OF MEDICINE PRESCRIBED AND SELECTED FROM THE APPROPRIATE BESTMED FORMULARY	DOSAGE	QUANTITY PER MONTH	HOW LONG HAS PATIENT BEEN ON MEDICINE?	HOW MANY REPEATS?

List medicine to be stopped or discontinued __________

5. DECLARATION OF ATTENDING DOCTOR

I declare that to the best of my knowledge, all the above information is true and accurate, based on the examinations and tests performed on this patient.

Surname __________ Initials __________

Discipline __________ Practice number __________

Tel (W) __________ Fax __________

E-mail __________

Doctor's signature __________

Date D D M M Y Y Y Y