Discovery Health

Discovery Health administers the Discovery Health Medical Scheme

CHRONIC ILLNESS BENEFIT (CIB) APPLICATION FORM 2003

This form is valid during 2003 only. Visit www.discovery.co.za or call us on 0860 99 88 77 for the latest version.

CIBE 01/02/2003

INSTRUCTIONS (please complete this application form as follows)

1. One application form must be completed per patient. This application must be completed in black ink.
2. The principal member or patient must complete Section 1 and Section 2. (Please make sure you complete both these sections in full.)
3. The doctor must complete the rest of the application form (Sections 6-9 are compulsory and Sections 3-5 where applicable.) We do not require a copy of your doctor's prescription. This must be presented to your pharmacy.
4. If the appropriate sections are not completed we will not be able to process your application.
5. Fax the completed and signed application form to: (011) 539 7000 or post to: CIB Department, Discovery Health, PO Box 652919, Benmore 2010.

1. PRINCIPAL MEMBER INFORMATION (to be completed by principal member or patient)

Surname Initials

Title Identity number

Date of birth (Y Y Y Y M M D D) Membership number

Postal address

Code

Telephone numbers Home Work

Cellular Fax

Employer name

2. IMPORTANT PATIENT INFORMATION (to be completed by principal member or patient)

Surname (if other) Title

First names

Date of birth (Y Y Y Y M M D D) Gender M F Mass (kg) Height (cm)

Relationship to principal member Identity number

Telephone numbers Home Work

Cellular Fax

E-mail address

May we communicate your confidential information via this e-mail address? YES NO or fax number YES NO or SMS YES NO

If you have faxed your application form and we have not communicated with you within 10 days via your preferred route of communication, please call us on 0860 99 88 77 to confirm receipt.

Do you smoke? YES NO For how long have you smoked? years How many cigarettes do you smoke? per day

I hereby give permission for my doctor to provide Discovery Health with my diagnoses and other relevant clinical information required to review my application for Chronic Illness Benefits. I understand that funding from the CIB is subject to clinical entry criteria and drug utilisation review as determined by Discovery Health. The CIB provides cover for disease modifying therapy only, which means that not all medicines for a listed condition are automatically covered by the CIB. By registering for the CIB, I agree that my condition may be subject to disease management interventions and periodic review and that this may include access to my medical records. I understand that non-compliance may lead to the withdrawal of this benefit.

Certain generic medication or therapeutic alternatives can significantly reduce prescription costs, while still providing the desired therapeutic effect. **Should a generic equivalent be available, this will be authorised instead of your prescribed medication unless your doctor has specified otherwise in Section 6 of this application form**. Should your application for the CIB be declined, you may choose to pay for your medication out of your Medical Savings Account, subject to the availability of funds and Discovery Health rules. Medication approved by the CIB will only be effective from date of receipt of an application form that is completed in full.

The covered CIB conditions and clinical entry criteria may change from time to time and the patient may be required to submit an updated/new application form if requested by the CIB.

I hereby give my consent that Discovery Health may, from time to time, disclose any information supplied to Discovery Health – including general or medical information – to my appointed health care intermediary or any other third party. I agree that Discovery Health may disclose this information at its sole discretion, but only as long as all the parties involved have agreed to keep the information confidential at all times.

Signed principal member

Patient (unless a minor)

PLEASE READ CAREFULLY TO CHECK WHETHER THE LISTED CONDITIONS REQUIRE COMPLETION OF THE RELEVANT SECTION OF THE APPLICATION FORM, ADDITIONAL TESTS, MOTIVATION OR SUPPORTING DOCUMENTATION. YOUR APPLICATION CANNOT BE PROCESSED IF THE ADDITIONAL INFORMATION IS NOT SUPPLIED. THE FOLLOWING 63 CONDITIONS WILL BE CONSIDERED FOR THE CHRONIC ILLNESS BENEFIT.

	CONDITION	SECTION(S) TO BE COMPLETED	CLINICAL ENTRY CRITERIA (CEC) REQUIREMENTS
A	Addison's Disease	6	None
	Ankylosing Spondylitis	6	1. Application form must be completed by a rheumatologist. 2. Please provide motivation for applications for Cyclooxygenase Inhibitors (COXIB's) over conventional non-steroidal anti-inflammatories.
	Arrhythmias of Cardiac Origin	6	None
	Asthma	3,6	1. The South African Treatment Guidelines for Asthma, as published in the SAMJ are applied to all applications. 2. Please submit lung function tests with applications for leukotriene inhibitors before and after use of the leukotriene inhibitor to substantiate the added benefit. Leukotriene inhibitors will only be considered as add on therapy to inhaled corticosteroids.
	Attention Deficit Hyperactivity Disorder (ADHD) (in Children under 16 years of age)	6	1. Application form must be completed by a paediatrician, psychiatrist or neurologist.
B	Benign Prostatic Hypertrophy (BPH)	6	None
	Bipolar Mood Disorder	5,6	1. Please supply DSM IV criteria in Section 5 i.e., symptoms that confirm this diagnosis (not the DSM IV Axis).
	Bronchiectasis	6	None
C	Cardiomyopathy	6	None
	Chronic Obstructive Pulmonary Disease (COPD) (Chronic Bronchitis and Emphysema)	3,6	1. Please attach a lung function test report. 2. Please attach a motivation when applying for oxygen including a. oxygen saturation levels without oxygen therapy b. number of hours of oxygen use per day
	Chronic Renal Failure	6	1. Please attach laboratory test reports that confirm the diagnosis of Chronic Renal Failure. 2. Please attach a report reflecting haemoglobin or haematocrit levels when applying for erythropoietin, indicating if the results are on or off drug therapy.
	Congestive Cardiac Failure	6	None
	Crohn's Disease	6	None
	Cushing's Disease	6	None
	Cystic Fibrosis	6	None
D	Delusional Disorder	5,6	Please supply DSM IV criteria in Section 5 i.e., symptoms that confirm this diagnosis (not the DSM IV Axis).
	Dermatopolymyositis	6	None
	Diabetes Mellitus Type 1	6	None
	Diabetes Mellitus Type 2	6	1. Please attach a laboratory report confirming the diagnosis of Type 2 diabetes. 2. Applications for thiazolidinediones over conventional therapy will only be considered from a specialist in this field.
E	Epilepsy	6	Please attach an EEG report confirming the diagnosis of epilepsy.
G	Gastro-Oesophageal Reflux Disease (GORD)	6	1. Please attach an **initial or diagnostic** gastroscopy report reflecting grade two or worse reflux oesophagitis. 2. Applications for the treatment of Negative Endoscopic Reflux Disease (NERD) must be motivated by a gastroenterologist.
	General Anxiety Disorder	5,6	Please supply DSM IV criteria in Section 5 i.e., symptoms that confirm this diagnosis (not the DSM IV Axis).
	Glaucoma	6	None
	Gout	6	Only allopurinol, benzbromarone and probenecid containing products are covered by CIB.
H	Haemophilia	6	None
	HIV / Aids (Antiretroviral Therapy)	**Do not complete this application form**	To enrol or request information on our HIV programme, please call us on 0860 100 417.
	Huntington's Disease	6	None
	Hyperlipidaemia (Primary Prevention) (High Cholesterol)	2, 4, 6	1. Please attach an **initial or diagnosing** fasting Lipogram report. 2. The South African Treatment Guidelines as published in the SAMJ are applied to all applications for primary prevention. This means that members with a 20% or greater risk of a coronary event in the next 10 years will be covered by the CIB. 3. Where family history is applicable for the diagnosis of Familial Hyperlipidaemia , please provide details in Section 4 of this application form, including age of family member at cardiovascular event and relationship to member. 4. If applicable, details of Hypertension must be completed in Section 4 of this application form. 5. If applicable, provide details of Diabetes Mellitus as indicated above. 6. Please provide the following details in Section 2 of this form: a. Smoking details b. Weight of patient c. Height of patient 7. If applicable, please attach details of signs of hypercholesterolaemia in this patient.
	Hyperlipidaemia (Secondary Prevention)	4, 6	1. Please attach an **initial or diagnosing** fasting Lipogram report. 2. Please provide details of cardiovascular event in Section 4.
	Hypertension	4,6	1. Please provide the following details in Section 4 of this application form: a. Two initial or diagnostic blood pressure readings i.e. before drug therapy was initiated. b. The current blood pressure reading c. Major risk factors, target organ damage (TOD) or clinical cardiovascular disease (CCD) for hypertension, relevant to this patient. 2. The South African Treatment Guidelines for hypertension, as published in the SAMJ, are applied to all applications for hypertension.

	CONDITION	SECTION(S) TO BE COMPLETED	CLINICAL ENTRY CRITERIA (CEC) REQUIREMENTS
	Hypoparathyroidism	6	Application form must be completed by a specialist physician
	Hypothyroidism	6	Please attach the **initial or diagnostic** laboratory report that confirms the diagnosis of hypothyroidism.
I	Ischaemic Heart Disease (including Angina Pectoris)	6	Applications for clopidogrel must be accompanied by a motivation from a cardiologist for use over aspirin therapy.
M	Major Depression	5,6	1. Please supply DSM IV criteria in Section 5 i.e., symptoms that confirm this diagnosis (not the DSM IV Axis). 2. The CIB is unable to accept any additional external tick box DSM IV criteria forms. Please complete DSM IV criteria in Section 5 of this form.
	Menopause	6	Please attach motivation for use of HRT in patients <40 years of age.
	Motor Neurone Disease	6	None
	Multiple Sclerosis	6	1. Please attach a report from a neurologist for applications for **beta-interferon** indicating: a. Relapsing - remitting history b. Relapses requiring treatment with cortisone c. Extended Disability Status Score (EDSS) 2. The CIB provides cover for beta-interferon for relapsing - remitting multiple sclerosis only, in patients under 55 years of age. 3. Beta-interferon is not covered by the CIB for Secondary Progressive MS.
	Muscular Dystrophy and other inherited myopathies	6	None
	Myasthenia gravis	6	None
N	Narcolepsy	6	Application form must be completed by a neurologist.
O	Obsessive Compulsive Disorder	5,6	Please supply DSM IV criteria in Section 5 i.e., symptoms in confirming this diagnosis (not the DSM IV Axis).
	Organ Transplant	6	None
	Osteopaenia	6	1. All applications must be accompanied by a DEXA Bone Mineral Density Scan (BMD) report. 2. Endocrinologist motivation required in females <30 years, males and children.
	Osteoporosis	6	1. All applications must be accompanied by a DEXA Bone Mineral Density Scan (BMD) report. 2. Endocrinologist motivation required in females <30 years, males and children. 3. Please attach information on additional risk factors in patient, where applicable.
P	Paget's Disease	6	None
	Panic Disorder	6	Please supply DSM IV criteria in Section 5 i.e., symptoms in confirming this diagnosis (not the DSM IV Axis).
	Paraplegia	6	None
	Parkinson's Disease	6	Applications for pramipexole, entacapone and tolcapone will only be considered from neurologists.
	Pemphigus	6	None
	Peripheral Arteriosclerotic Disease	6	None
	Pituitary Microadenomas	6	None
	Post Traumatic Stress Syndrome	5,6	Please supply DSM IV criteria in Section 5 i.e., symptoms in confirming this diagnosis (not the DSM IV Axis).
	Pulmonary Interstitial Fibrosis	6	None
Q	Quadriplegia	6	None
R	Rheumatoid Arthritis	6	1. Please attach relevant copies of blood test reports and supportive clinical history confirming the diagnosis of rheumatoid arthritis We recognise that there are other conditions that may be closely related to rheumatoid arthritis. However, only rheumatoid arthritis is covered by the CIB. 2. Applications for anti-inflammatories as monotherapy must be motivated for by a rheumatologist. 3. Applications for Cyclooxygenase Inhibitors (COXIB's) must be accompanied by a motivation for use over conventional anti-inflammatories.
S	Schizophrenia	5,6	Please supply DSM IV criteria in Section 5 i.e., symptoms in confirming this diagnosis (not the DSM IV Axis).
	Stroke	6	Applications for clopidogrel must be accompanied by a motivation from a neurologist for use over aspirin therapy.
	Systemic Lupus Erythematosus	6	Application form must be completed by a rheumatologist or specialist physician.
	Systemic Sclerosis	6	Application form must be completed by a rheumatologist or specialist physician.
T	Thromboangiitis Obliterans	6	None
	Thrombocytopaenic Purpura	6	None
	Tic Disorder (Tourette Syndrome)	6	1. Application form must be completed by a neurologist or psychiatrist. 2. Botulinum toxin is not covered from the CIB.
U	Ulcerative Colitis	6	None
V	Valvular Heart Disease	6	1. Antibiotics are not funded from the CIB. 2. Barlow syndrome is not covered by the CIB.

RULES APPLICABLE TO CHRONIC ILLNESS BENEFIT (CIB)

1. Although your condition may be defined as chronic by your doctor, certain conditions and medicines do not fulfil Discovery Health's criteria necessary for acceptance under the CIB.
2. Exclusions from CIB include these commonly requested medicines:
   • Vitamins and mineral preparations • Antibiotics • Homeopathic medicines • Mucolytics • Antihistamines • Hypnotics • Symptomatic therapy
3. All plans have limited cover for your chronic medicine. However if you are on the Classic or Essential Standard Medical Scheme option you may choose the Max option within 30 days of being approved by the CIB. The Max option offers you unlimited cover for your ***approved*** chronic medication.

If you have any questions or concerns please call: The Chronic Illness Benefit Call Centre on 0860 99 88 77 or visit our website at www.discovery.co.za
You may also track the status of your CIB Application form and access your approved and declined medicines on our website.

Patient name and membership number

3. APPLICATION FOR RESPIRATORY CONDITIONS (to be completed by the doctor)

Please tick relevant block:

ASTHMA: Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐

COPD: Stage I ☐ Stage II ☐ Stage III ☐

RESTRICTIVE LUNG DISEASE: ☐

4. APPLICATION FOR HYPERTENSION AND HYPERLIPIDAEMIA (to be completed by the doctor)

Please complete the table below and supply details of family history of cardiovascular disease for all applications for Hypertension and Hyperlipidaemia

Major Risk Factors (tick if applicable)		**Target Organ Damage (TOD)/Clinical Cardiovascular Disease (CCD)**	
Smoking		**Heart Diseases**	
Dyslipidaemia		LVF	
Diabetes Mellitus		Angina/prior MI	
Age > 60 years		Prior CABG – Coronary Artery Bypass Graft	
Gender		Heart Failure	
Male		Stroke/TIA	
Postmenopausal women		Nephropathy	
		Peripheral arterial disease	
		Hypertensive retinopathy	

Is there a family history of cardiovascular disease? YES ☐ NO ☐

If Yes, please provide details below of relative and age at event and/or death

Please complete this section for applications for Hyperlipidaemia (Secondary Prevention).

Please provide details of patient's cardiovascular event

Please complete this section for applications for Hypertension

i) Please supply report of 24 hour Ambulatory Blood Pressure Monitoring if available

ii) Please supply two initial blood pressure readings (i.e., before drug therapy was commenced) done at least 2 weeks apart.

1. _____ / _____ mm Hg Date _____ / _____ / _____

2. _____ / _____ mm Hg Date _____ / _____ / _____

iii) Please supply current blood pressure reading _____ / _____ mm Hg Date _____ / _____ / _____

5. APPLICATION FOR MENTAL ILLNESS (to be completed by the doctor)

- All applicants with mental illnesses described in the CIB approved list are required to have this section completed.
- This section may only be completed by the treating Doctor for CIB consideration. Motivations from psychiatrists may be requested.
- The DSM IV criteria below (not the DSM IV Axis) must be completed.
- CIB approval will not be granted where insufficient Clinical Information has been provided.
- Additional external DSM IV tick box forms will not be accepted by the CIB.

1. Diagnosis (DSM IV)
2. Date first diagnosed Family History of mental illness YES ☐ NO ☐

DSM IV Criteria i.e. symptoms identified in confirming the diagnosis above - Do not supply DSM IV Axis
(Completion of the DSM IV Criteria for Section 5 is compulsory)

a. _____ e. _____

b. _____ f. _____

c. _____ g. _____

d. _____ h. _____

3. Number of relapses since initial diagnosis Duration of last episode
4. History of hospitalisation/institutionalisation with respect to the above mentioned illness

Details of psychiatrist (where applicable)

Name

BHF Practice number Signature

Patient name and membership number

6. CURRENT MEDICATION REQUIRED (to be completed by the doctor)

The Chronic Illness Benefit provides cover for **disease-modifying therapy** only for 63 listed conditions. Medication used for symptomatic control is not covered by the CIB.

Diagnosis	Date when condition was first diagnosed	Medication name, strength and dosage	Monthly Quantity	How long has the patient used this medication?		Repeats
				Years	Months	

Medication will be substituted with a generic where appropriate, unless you specify otherwise per medication below:

7. PAST MEDICAL/SURGICAL HISTORY (to be completed by the doctor)

Has the patient had a hysterectomy? YES ☐ NO ☐ Oophorectomy? YES ☐ NO ☐ Osteoporotic related fracture? YES ☐ NO ☐

Year	Diagnosis	Medication and strength	Duration of use

8. DOCTOR'S PARTICULARS (to be completed by the doctor)

Name	
Telephone number	Fax number
Speciality	E-mail
BHF Practice number	

Doctor's signature Date Y Y Y Y M M D D

NOTE TO DOCTOR: DOCTOR'S FEE FOR COMPLETION OF THIS FORM WILL BE REIMBURSED ON BHF CODE 0133, ON SUBMISSION OF A SEPARATE CLAIM ONLY WHEN THE PATIENT IS AN ACTIVE DISCOVERY HEALTH MEMBER. PAYMENT OF THE CLAIM IS FROM THE MEDICAL SAVINGS ACCOUNT, SUBJECT TO THE MEMBER'S PLAN AND AVAILABILITY OF FUNDS. INCOMPLETE APPLICATIONS WILL NOT BE ELIGIBLE FOR CIB REVIEW.