primecure

Chronic Medicine Benefit Application Form

IMPORTANT NOTE: This form must be completed by the treating doctor. For a list of approved conditions, please 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:

Please select where the member would like to collect their medication.

- ◯ Dispensing GP
- ◯ Prime Cure Network Pharmacy: Find a Prime Cure Network povider at www.primecure.co.za
- ◯ 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/Option:

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:

Make a selcection

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

kaelo

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 Measured: y y y y - m m - d d

Glucose: Date Measured: y y y y - m m - d d

Random Blood Glucose: Fasting Blood Glucose:

Glucose Tolerance Test (GTT): HbA1c:

Lipogram: Date Measured: y y y y - m m - d d

Total Cholesterol: HDL:

LDL: Triglyceride:

Creatinine Clearance: Date Measured: y y y y - m m - d d

Microalbuminuria: Date Measured: y y y y - m m - d d

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

FEV1: FEV/FEC:

Indicate if the patient has the following:

◯ Ischaemic Heart Disease/Myocardial Infarction Date: y y y y - m m - d d

◯ Peripheral Vascular Disease Date: y y y y - m m - d d

◯ Atherosclerosis Date: y y y y - m m - d d

◯ Transient Ischaemic Attack/Stroke Date: y y y y - m m - d d

First degree relative with premature heart disease:

◯ Female < 65 Years ◯ Male < 55 Years

G Chronic Medication:

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

Address: 2nd Floor, The Oval - East Wing, Wanderers Office Park, 52 Corlett Drive, Illovo, 2196
Telephone: 0861 665 665; Email: pcauth@mediscor.co.za; Web: www.kaelo.co.za
Company Directors: J Jutzen, M Jordan
Non-Executive Directors: K Bouic, Z Omar
Registered Company Name: Kaelo Prime Cure (Pty) Ltd
Reg. No. 1997 / 017429 / 07

kaelo

H Clinical Motivation/Additional Comments:

Doctor Signature:

Application Date: y y y y - m m - d d

I Member/Policyholder Consent:

I,_____ (full name) Identity number _____
consent to the sharing of my clinical information pertaining to my Chronic Medicine Benefit application, and management thereof with Prime Cure. I also consent to Prime Cure sharing my clinical information with any other healthcare professional involved in the management of my condition, including hospital risk management professionals appointed by the Medical Scheme/Health Insurer or the Scheme's administrator, provided that this information will not be made available to my employer(s) or any other person not involved in my healthcare, or case management, without my express written consent. I 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 held 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

Address: 2nd Floor, The Oval - East Wing, Wanderers Office Park, 52 Corlett Drive, Illovo, 2196
Telephone: 0861 665 665; Email: pcauth@mediscor.co.za; Web: www.kaelo.co.za
Company Directors: J Jutzen, M Jordan
Non-Executive Directors: K Bouic, Z Omar
Registered Company Name: Kaelo Prime Cure (Pty) Ltd
Reg. No. 1997 / 017429 / 07

kaelo