CAMAF
MEDICAL SCHEME
IN A CLASS OF ITS OWN

APPLICATION FORM - CHRONIC MEDICINE BENEFIT

1. Please complete this form to apply for Chronic Medicine Benefits.
2. One form must be completed per patient.
3. Once completed please email, fax or post to:
   Email: clinicalrisk@camaf.co.za
   Fax no: 011 707 8622
   Post: CAMAF, P.O. Box 2964, Randburg, 2125
4. Forms not completed in full will not be processed.
5. Section 1 of the application form must be completed by the member.
6. Sections 2 and 3 are for information purposes only and must not be sent back to CAMAF.
7. Sections 4-7 must be completed by your doctor.
8. You will qualify for chronic benefits only once your application has been approved.
9. Reference Pricing applies to all chronic medicine. Please refer to our website or contact us on: 0861 700 600 (option 3) for more details to ensure that you do not incur a co-payment.
10. CAMAF has appointed a Pharmacy Network for dispensing of chronic medicine. Should you choose not to purchase your chronic medicine from a Network Pharmacy a co-payment will apply. Please refer to CAMAF's website for a list of pharmacies in the network.
11. For any queries relating to the Chronic Medicine Benefit please contact the Clinical Risk Management Department on 0861 700 600 option 3 or alternatively email us at clinicalrisk@camaf.co.za
12. Attach copies of any reports to support the diagnosis of chronic conditions, where applicable.

1. PATIENT INFORMATION Please tick (✔) applicable box

Surname Initials

Full Name(s)

Membership No.:

RSA Identity No./Passport No. Gender (M=Male; F=Female)

Date of Birth D D M M C C Y Y

Telephone:

Home Code No. Cell No.

Work Code No. Fax Code No.

E-mail Address

We can contact you for feedback on your application via email ☐ or fax ☐

I understand that my application will not be processed if the information on this form is incomplete or the relevant diagnostic results are not provided to CAMAF. I give permission to my doctor to provide CAMAF with my diagnosis and other relevant clinical information to review my PMB application.

Principal Member Signature | Patient/Guardian Signature | Date

INSTRUCTION: To be taken to your doctor for information purposes

2. CLINICAL ENTRY CRITERIA FOR THE PRESCRIBED MINIMUM BENEFITS (PMB) CHRONIC DISEASE LIST (CDL)

These conditions are reimbursed on all CAMAF options provided the Clinical Entry Criteria is met as indicated below

CDL Condition	Clinical Entry Criteria (must include ICD 10 code)
Addison's Disease	1. Diagnosis to be confirmed by an Endocrinologist, Paediatrician or Specialist Physician. 2. Diagnostic Serum cortisol levels and ACTH stimulation test results
Asthma	1. Diagnosis to be confirmed by a Pulmonologist, Paediatrician or Specialist Physician. 2. Lung Function Test for children 5 years and older and for adults
Bipolar Mood Disorder	Diagnosis to be confirmed by Psychiatrist
Bronchiectasis	Diagnosis to be confirmed by a Pulmonologist or Specialist Physician
Cardiac Failure	Diagnosis to be confirmed by a Cardiologist or Specialist Physician
Cardiomyopathy	Diagnosis to be confirmed by a Cardiologist or Specialist Physician
Chronic Obstructive Pulmonary Disease (COPD)	1. Diagnosis to be confirmed by a Pulmonologist 2. Diagnostic Lung Function Test (LFT) 3. Motivation for oxygen use - FEV1 with oxygen saturation levels and hours of oxygen used per day
Chronic Renal Failure	1. Diagnosis to be confirmed by a Nephrologist or Specialist Physician 2. Diagnostic Creatinine Clearance or Glomerular Filtration Rate (GFR) 3. Hb results when applying for erythropoetin
Coronary Artery Disease	Diagnosis to be confirmed by a Cardiologist or Specialist Physician
Crohn's Disease	1. Diagnosis to be confirmed by a Gastroenterologist, Surgeon or Specialist Physician 2. Diagnostic Colonoscopy results required
Diabetes Insipidus	1. Diagnosis to be confirmed by an Endocrinologist, Paediatrician or Specialist Physician 2. Results of Water Deprivation Test required
Diabetes Mellitus Type 1 and 2 (Please refer to section 6)	1. Pathology results required confirming the diagnosis of Diabetes, including either Fasting glucose, Random glucose or HbA1c values.
Dysrhythmias	Diagnosis to be confirmed by a Cardiologist or Specialist Physician
Epilepsy	Diagnosis to be confirmed by a Neurologist, Specialist Physician or Paediatrician
Glaucoma	Diagnosis to be confirmed by an Ophthalmologist
Haemophilia (A + B)	1. Diagnosis to be confirmed by a Specialist Physician or Haematologist 2. Pathology report indicating Factor VIII or IX levels
HIV / Aids	Member to register with LifeSense HIV Management Programme on 0860 50 60 80
Hyperlipidaemia - (Please refer to section 5)	1. Diagnostic Lipogram required - must include LDL, HDL, Total Cholesterol and Triglyceride values 2. Familial Hyperlipidaemia requires an Endocrinologist diagnosis 3. Most recent Lipogram should medicine change or dose increase
Hypertension - (Please refer to section 4)	1. Diagnostic BP readings required for newly diagnosed patients 2. Patients younger than 30 years must be diagnosed by a Cardiologist
Hypothyroidism	Diagnostic Thyroid function test results including TSH and FT4
Multiple Sclerosis	1. Diagnostic confirmation from a Neurologist or Specialist Physician 2. Following information is required when applying for medicine benefits for Interferon a. MRI reports b. Relapsing - remitting history c. Extended Disability Status Score (EDSS) d. Relapses requiring cortisone therapy
Parkinson's Disease	Diagnosis confirmation from a Neurologist or Specialist Physician
Rheumatoid Arthritis	1. Diagnosis confirmation from a Rheumatologist, Paediatrician or Specialist Physician 2. Blood results, clinical history confirming diagnosis and SDAI / CDAI scores
Schizophrenia	Diagnosis confirmation from a Psychiatrist
Systemic Lupus Erythematosus	Diagnosis confirmation from a Specialist Physician or Rheumatologist
Ulcerative Colitis	1. Diagnosis to be confirmed by a Gastroenterologist, Specialist Physician or Surgeon 2. Diagnostic Colonoscopy / Sigmoidoscopy report required

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3. CLINICAL ENTRY CRITERIA FOR THE ADDITIONAL CHRONIC CONDITIONS

Theseconditionsarereimbursedon theAlliance,DoublePlusandVitaloptionsprovidedtheClinicalEntryCriteriaismetasindicatedbelow

Additional Chronic Condition	Clinical Entry Criteria (must include ICD 10 code)
Allergic Rhinitis	Diagnosis to be confirmed by an ENT, GP or Pulmonologist
Alzheimer's Disease	1. Diagnosis to be confirmed by a Psychiatrist, Neurologist or Geriatrician 2. Must include Mini mental report
Ankylosing Spondylitis	Diagnosis to be confirmed by a Specialist Physician or Rheumatologist
Attention Deficit Hyperactivity Disorder (ADHD) (Alliance Option Only)	Diagnosis to be confirmed by a Paediatrician or Psychiatrist
Chronic Granulomatous Disease	Diagnosis to be confirmed by a Specialist Physician
Cystic Fibrosis	Diagnosis to be confirmed by a Pulmonologist, Paediatrician or Specialist Physician
Deep Vein Thrombosis	1. Diagnosis to be confirmed by a Specialist Physician or GP 2. For GP diagnosis Doppler Ultrasound required
Eczema	Diagnosis to be confirmed by a GP, Paediatrician or Dermatologist
Gastro - Oesophageal Reflux Disease (GORD)	1. Diagnosis to be confirmed by a Gastroenterologist or Surgeon 2. Gastroscopy report required
Gout Prophylaxis	1. Only preventative therapy will be reimbursed 2. Uric acid test results required
Major Depression	1. Diagnosis to be confirmed by a GP (adults only) or Psychiatrist 2. Only generic first line therapy will be reimbursed from the GP script
Meniere's Disease	Diagnosis to be confirmed by an ENT
Migraine Prophylaxis	1. Diagnosis to be confirmed by a Specialist Physician or Neurologist 2. Only preventative therapy will be reimbursed
Myasthenia Gravis	Diagnosis to be confirmed by a Specialist Physician or Neurologist
Osteoarthritis	Diagnosis to be confirmed by a GP or Rheumatologist
Osteoporosis	1. Diagnosis to be confirmed by a GP, Specialist Physician or Gynaecologist 2. Dexa Bone Mineral Densitometry (BMD) report required 3. Clinical history including risk factors
Psoriasis	Diagnosis to be confirmed by a Dermatologist
Restrictive Lung Disease	1. Diagnosis to be confirmed by a Pulmonologist or Specialist Physician. 2. LFT results required

For Information Purposes Only - Do Not send back

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Patient's Full Name

Patient's Surname

Membership Number

The sections below must be completed by the relevant doctor:

4. APPLICATION FOR HYPERTENSION

1. ICD 10 Code _____
2. Height (m) ____ Weight (kg) ____
3. Diagnostic BP (prior to drug therapy)
   - i. Date D D M M C C Y Y _____ / _____ mmHg
   - ii. Date D D M M C C Y Y _____ / _____ mmHg
4. When did the patient commence drug therapy for Hypertension? D D M M C C Y Y
5. Current blood pressure _____ / _____ mmHg
6. Please indicate below if there is target organ damage and / or cardiovascular disease:

- ☐ Angina
- ☐ Cardiac Failure
- ☐ Chronic Renal Disease
- ☐ Hypertensive Retinopathy
- ☐ Left Ventricular Hypertrophy
- ☐ Myocardial Infarction
- ☐ Nephropathy
- ☐ Peripheral Vascular Disease
- ☐ Prior CABG
- ☐ Prior Stent / Angioplasty / Angiogram
- ☐ Stroke / TIA

7. Please provide clinical information for use of drug classes that are not first or second line therapy

_____

_____

_____

_____

_____

_____

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The sections below must be completed by the relevant doctor:

5. APPLICATION FOR HYPERLIPIDAEMIA

1. Please attach diagnosing lipogram as well as the most recent lipogram
2. ICD 10 Code _____
3. Height (m) ____ Weight (kg) ____
4. Does the patient smoke? Y N
5. Is there a family history of Arteriosclerotic disease? Y N

   If yes please complete table below:

	Mother	Father	Sister	Brother
Event details				
Age at time of event				

6. When did the patient commence drug therapy for Hyperlipidaemia? D D M M C C Y Y
7. Current blood pressure _____ / _____ mmHg if not completed in Section 4
8. Current fasting glucose _____ / _____ mmol / L (Only for Primary Hyperlipidaemia)
9. TSH _____ (Only for Primary Hyperlipidaemia)
10. Does the patient have Familial Hyperlipidaemia (FH)? Y N

    Please list signs of FH:

_____

_____

_____

_____

_____

_____

_____

11. Please indicate whether application is for primary ☐ or secondary ☐ prevention.

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6. APPLICATION FOR DIABETES MELLITUS

1. ICD 10 Code _____
2. Height (m) ☐☐☐☐ Weight (kg) ☐☐☐☐ Waist Circumference (cm) ☐☐☐☐
3. Does the patient smoke? Y N
4. Current blood pressure _____ / _____ mmHg
5. TSH ☐☐☐☐☐☐☐☐
6. Please indicate below if there is target organ damage and / or cardiovascular disease:

☐ Angina	☐ Chronic Renal Disease
☐ Stroke	☐ Dialysis
☐ Myocardial Infarction	☐ Neuropathy
☐ Cardiac Failure	☐ Limb Amputation
☐ Left Ventricular Hypertrophy	☐ Retinopathy
☐ Stent / Angioplasty	☐ Glaucoma
☐ CABG	☐ Blindness
☐ Peripheral Vascular Disease	

7. Please provide a family history of Diabetes and Cardiovascular Disease in the table below:

	Mother	Father	Sister	Brother
Event details				
Age at time of event				

8. When did the patient commence drug therapy for Diabetes? D D M M C C Y Y
9. Please provide a history of diabetes treatment.

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Patient's Surname

Membership Number

The sections below must be completed by the relevant doctor:

7. CURRENT MEDICINE DETAILS

Please refer to Sections 2 and 3 for information relating to Clinical Entry Criteria.

Please note that Reference Pricing applies. Refer to CAMAF's website or contact the Clinical Risk Management Department to ensure that the member does not incur a co-payment.

Diagnosis	ICD 10 Code	Date of Diagnosis	Medicine Name and Strength	Dosage/ Quantity per month	How long has the patient used this medicine		Repeats
					Years	Months	

8. DOCTOR DETAILS

Name

BHF Practice Number

Speciality

Telephone: Work

Fax Number

Doctor's Signature

Date D D M M C C Y Y

1. Please ensure all relevant reports and / or tests are included with this application form.
2. For completion of this application form use claim code 0199. Please remember to use the relevant ICD 10 code with the claim.
3. This form only needs to be completed when applying for a new chronic condition. For any changes to the patient's medicine for approved conditions please call 0800 200 300.