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. **Please refer to your product brochure for the conditions covered on your chosen benefit option.**
9. **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), e-mail medicine@bestmed.co.za 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
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)
Cerebral Palsy	Prescription required from a neurosurgeon, neurologist, paediatric neurologist or paediatrician. Attach supporting clinical diagnostic report
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
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

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Multiple sclerosis	Prescription required from a neurologist with supporting scans for initial applications. Attach a report from a neurologist for applications for biologicals indicating: a. Relapsing – remitting history b. Extended disability status score (EDSS)
Osteoporosis	Most recent Bone Mineral Density (BMD) test results required
Oxygen therapy	For initial applications: ▪ Prescription from doctor should accompany all oxygen service provider request forms ▪ Recent blood gas report For extensions: Compliance report with meter readings
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

CHRONIC MEDICINE APPLICATION FORM

Sections 1, 2 and 3 must be completed by the member.

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

1. PARTICULARS OF THE PATIENT

Surname

First name

Membership number

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

2. 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.

3. 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. Bestmed may identify other products and services which might be of interest to me, as well as to inform me of such products and/or services.

Yes	No

Signature of applicant

IMPORTANT

Without the correct diagnosis codes (ICD-10 codes), 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