momentum
carecross

Call Centre: 0860 102 182 Fax: 021 673 1815
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Chronic Benefit application

Section 1: Member's details

First name | Surname
Title | Membership number
Medical scheme | Option

Section 2: Patient's details

First name | Surname
Title | Dependant Code
Date of birth (D D M M Y Y Y Y)
Postal address
Postal code
Telephone - home | Telephone - work
Fax number | Cellphone number
Email address

Section 3: Patient's medical history

Weight | Height | BMI | Gender: Male ☐ Female ☐

Smoking status	Yes ☐	No ☐	Ex-smoker	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Treatment	On ☐	Off ☐
Hyperlipidaemia	Yes ☐	No ☐	Treatment	On ☐	Off ☐
Blood pressure ___ / ___			Ischaemic IHD	Yes ☐	No ☐
Bypass Surgery	Yes ☐	No ☐	Previous Myocardial Infarction	Yes ☐	No ☐
TIA	Yes ☐	No ☐			
Other major disease	Yes ☐	No ☐	Please provide details		

Environmental allergies	Medicine allergies
1.	1.
2.	2.

Script details

New Application ☐ Update ☐ Treatment Change ☐

Diagnosis (e.g. Hypertension)	ICD10 Code (e.g. J10)	Medication description	Strength (e.g. 25mg)	Directions (e.g. 1/Daily)	Date of diagnosis (month and year)	Repeats (e.g. 6/12)
					M M Y Y Y Y	
					M M Y Y Y Y	
					M M Y Y Y Y	
					M M Y Y Y Y	
					M M Y Y Y Y	

*CareCross requires a copy of the first and latest Lipogram, and Risk Evaluation form, where applicable, to prevent a delay in the assessment of the application.

Section 4: Doctor's details

Surname | Initials | Qualifying degree
Practice number | HPCSA reg number
Telephone | Fax
Practice address

Section 5: Pharmacy preference

Patient's choice of retail pharmacy ☐ Courier pharmacy ☐

Patient's details

Name | Medical aid number

Telephone number | Date of birth D D M M Y Y Y Y

Section 6: Declaration by General Practitioner

I have verified this application against the Medicine List as well as the List of Exclusions in terms of the CareCross Benefit. I agree to generic substitution, where a cost effective, less expensive alternative exists. I hereby declare that the information provided is true and correct.

Signature of General Practitioner | **Date** D D M M Y Y Y Y

Section 7: Declaration by member

I hereby authorise my doctor to furnish and/or disclose any fact relevant to this application. I agree that my diagnosis and medical results may be made available to CareCross Health in order to facilitate the processing of this application. I understand that approval is subject to the CareCross Chronic Medicine Formulary as well as the List of Exclusions in terms of the CareCross Benefit.

Signature of member
If minor, principal member must sign | **Date** D D M M Y Y Y Y

Motivation for lipid-lowering therapy

Lipogram 1: Pre-treatment	Lipogram 2
Date D D M M Y Y Y Y	Date D D M M Y Y Y Y
Total cholesterol	On or off therapy
LDL-cholesterol	Total cholesterol
HDL-cholesterol	LDL-cholesterol
Lipoprotein	HDL-cholesterol
ApoB	Lipoprotein
Triglycerides	ApoB
	Triglycerides

Clinical information

Does the patient have evidence of atherosclerotic disease?

Ischaemic heart (e.g. angina, myocardial infarction, previous coronary artery bypass craft)

Cerebrovascular disease (e.g. transient ischaemic attack, stroke carotid bruits)*

Peripheral vascular disease (e.g. intermittent claudication, absent peripheral pulses)*

Other (please specify)*

*Please provide full details

Does the patient have other cardivascular risk factors?

Smoker (indicate no. of cigarettes per day) | Diabetes mellitus

Obesity (weight kg height m BMI kg/m^2)

Hypertension Yes ☐ No ☐ (Blood pressure / on or off therapy)

Family history of cardiovascular disease in first-degree relative before age 55 (for first-degree male relatives) and 65 (for first degree female relatives)

(please specify)

Does the patient have clinical features of hyperlipidaemia?

Xanthoma | Xanthelasma | Arcus cornealis

Has the patient had any of the following investigations? (Please indicate results where appropriate)

TSH | Urine dipstix | Random blood glucose /glucose tolerance test

Liver function tests | Serum urea/creatinine

Has any lifestyle modification been attempted? | If yes, for how long?