

APPLICATION FORM

MEDICINE RISK MANAGEMENT PROGRAMME

IMPORTANT INFORMATION TO NOTE BEFORE COMPLETING THIS FORM

- Please book time with your doctor in order for him/her to examine you and complete this form. The ideal person to do this is the GP who regularly prescribes your medication. Please keep a copy of the completed form for your records.
- Prescribed Minimum Benefit rules, chronic disease lists and medication formularies applicable to your benefit option will apply.
- Member/patient signature on this form is essential to process this application.
- You will be informed in writing, should you be accepted onto the Medicine Risk Management (MRM) Programme. You will receive a chronic authorisation letter which will list the diagnosis you are registered for as well as the medication that will be paid from the chronic benefit subject to the rules of your benefit option.

How to complete this form:

- Complete the form in black ink and print clearly, or complete the form digitally.
- All relevant sections must be physically signed and cannot be signed digitally. The patient must sign and date any changes.
- Complete and sign sections 1 and 4.
- Take the application form to your doctor to complete section 2 and other relevant sections, sign and attach any test results, clinical reports or other information that we need to review the request. These requirements are shown in section 6.
- Send the completed application form and all supporting documents by email to chronic@imperialmotusmed.co.za.

PLEASE USE BLOCK LETTERS FOR ALL SECTIONS

1. MEMBER AND PATIENT INFORMATION

TO BE COMPLETED BY APPLICANT

MAIN MEMBER DETAILS

Benefit option	<input type="checkbox"/> Health Plan	<input type="checkbox"/> Budget Plan
Membership number	<input type="text"/>	
Surname	<input type="text"/>	
Title	<input type="text"/>	Initials <input type="text"/>
Email address	<input type="text"/>	

PATIENT DETAILS

Name and surname	<input type="text"/>		
Title	<input type="text"/>	ID number	<input type="text"/>
Beneficiary code	<input type="text"/>		
Physical address	<input type="text"/>		
	<input type="text"/>	Postal code	<input type="text"/>
Email address	<input type="text"/>		
Contact numbers	<input type="text"/>	Home	Cell phone <input type="text"/>
	<input type="text"/>	Work	

Membership number	<input type="text"/>	Doctor's practice number	<input type="text"/>
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1. MEMBER AND PATIENT INFORMATION (CONTINUED)

TO BE COMPLETED BY APPLICANT (CONTINUED)

Member consent

I understand that Imperial and Motus Medical Aid (Imperial Motus Med) and Momentum Health, the Administrator, will maintain the confidentiality of my personal information and comply with the Protection of Personal Information Act 4 of 2013 (POPIA) and all existing data protection legislation, when collecting, processing and storing my personal information for the purposes of registration on the Medicine Risk Management (MRM) Programme.

I understand that:

- Funding from the chronic benefit is subject to meeting benefit entry criteria requirements as determined by the Scheme.
- The chronic benefit provides cover for disease-modifying therapy only, which means that not all medication for a listed condition will automatically be covered by the chronic benefit.
- By registering for the chronic benefit, 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.
- Funding for medication from the chronic benefit will only be effective once the Scheme receives an application form that is completed in full. Please refer to the table in Section 6 to see what additional information is required to be submitted for the condition(s) for which you are applying.
- Payment to the healthcare professional for the completion of this form, on submission of a claim, is subject to Scheme rules and where the member is a valid and active member at the service date of the claim.
- I agree to my information being used to develop registries. This means that you give permission for us to collect and record information about your condition and treatment. This data will be analysed, evaluated and used to measure clinical outcomes and make informed funding decisions.
- To ensure that we pay your claims from the correct benefit, any claims from your healthcare providers must include the relevant ICD-10 diagnosis code(s). Please ask your doctor to also include the relevant ICD-10 diagnosis code(s) on the referral form for any pathology and/or radiology tests. This will enable the pathologists and radiologists to also include the relevant ICD-10 diagnosis code(s) on the claims they submit, thus further ensuring that we pay your claims from the correct benefit.

Consent for processing my personal information

1. I hereby acknowledge that Imperial Motus Med has appointed Momentum Health (Pty) Ltd as the administrator of the programme and that any prescribed medical treatment shall be the sole responsibility of my medical practitioner. I understand that the information provided on this form shall be treated as confidential and will not be used or disclosed except for the purpose for which it has been obtained.
2. I hereby give my consent to the Scheme, Momentum Health and its employees to obtain my, or any of my dependants', special personal information (including general, personal, medical or clinical), whether it relates to the past or future (e.g. health and biometric) from my healthcare providers (e.g. pharmacist, pathologist, radiologist, treating doctor and/or specialist) to assess my medical risk, enrol me on the programme and to use such information to my benefit and to undertake managed care interventions related to my chronic condition(s).
3. I understand that this information will be used for the purposes of applying for and assessing my funding request for chronic benefits.
4. I give permission for my healthcare provider to provide the Scheme and the administrator with my diagnosis and other relevant clinical information required to review and process my application.
5. I consent to the Scheme and the administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical) to my healthcare provider, to administer the chronic benefits.
6. Whilst Momentum Health undertakes to take all reasonable precautions to uphold the confidentiality of information disclosed to it, I am aware that the Scheme and my healthcare provider (where necessary) shall also gain access to the same information. I shall therefore not hold Momentum Health and its employees or the Scheme and its trustees, liable for any claims by me or my dependants arising from any unauthorised disclosure of my special personal information to other parties.
7. I understand and agree that special personal information relevant to my current state of health may be disclosed to third parties for the purpose of scientific, epidemiological and/or financial analysis without disclosure of my identity.

I, the undersigned, hereby declare that I have carefully read this application form, completed the applicable sections in full, and confirm that all the information provided herein is true and correct to the best of my knowledge.

Member/patient signature
(or signature of parent/legal
guardian if patient is under
the age of 18)

Date DD/MM/YYYY

Membership number

Doctor's practice number

2. MEDICAL PRACTITIONER'S INFORMATION AND CLINICAL EXAMINATION

TO BE COMPLETED BY ATTENDING MEDICAL PRACTITIONER

DOCTOR'S DETAILS

Surname	<input type="text"/>	Initials	<input type="text"/>
Speciality	<input type="text"/>		
Practice number	<input type="text"/>		
Contact numbers	<input type="text"/>	Work	Cell phone <input type="text"/>
Physical address	<input type="text"/>		
	<input type="text"/>	Postal code	<input type="text"/>
Email address	<input type="text"/>		

ASSOCIATED SPECIALIST DETAILS

Surname	<input type="text"/>	Initials	<input type="text"/>
Speciality	<input type="text"/>		
Practice number	<input type="text"/>		

CLINICAL EXAMINATION

Sex	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Other	Weight	<input type="text"/>	kg	BMI	<input type="text"/>	
				Height	<input type="text"/>	cm	Waist circumference	<input type="text"/> cm	
Blood pressure	Initial	<input type="text"/>	mmHg	Date	<input type="text" value="DD/MM/YYYY"/>				
	Present	<input type="text"/>	mmHg	Date	<input type="text" value="DD/MM/YYYY"/>				
Smoking/vaping	<input type="checkbox"/> Never			Started	<input type="text" value="MM/YYYY"/>	Stopped	<input type="text" value="MM/YYYY"/>	Average per day	<input type="text"/>
	<input type="checkbox"/> Ex							Average per day	<input type="checkbox"/> <3 <input type="checkbox"/> 3 - 20 <input type="checkbox"/> >20
	<input type="checkbox"/> Present			Started	<input type="text" value="MM/YYYY"/>				
Exercise	<input type="checkbox"/> Never	<input type="checkbox"/> <1 hour per week		Allergies	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Sulphonamides		
	<input type="checkbox"/> 1-3 hours per week	<input type="checkbox"/> >3 hours per week		Other	<input type="text"/>				

Please indicate if the patient has a history of the following:

Ischaemic heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Peripheral vascular disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
TIA/Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Membership number

Doctor's practice number

3. MEDICATION PRESCRIBED

Please indicate below where you agree to a generic substitution and provide your preferred medication name. Chronic medication is subject to formularies and generic reference pricing.

ICD-10 code(s) and diagnosis	Medication name and date started (DD/MM/YYYY)	Strength (e.g. 50mg)	Directions (e.g. 2tds)	Special motivation/ investigations	Specialist's details (Practice number and name)	Treatment on previous medical scheme(s) for diagnosis* Yes/No?

* If you answer 'yes', please indicate the medical scheme name and supply proof of previous chronic registration.

4. MEDICATION STOPPED

ICD-10 code(s)	Diagnosis	Name (trade name or generic equivalent)	Strength (e.g. 50mg)	Directions (e.g. 2tds)	Date medication stopped (DD/MM/YYYY)

Membership number

Doctor's practice number

5. PATIENTS WITH HYPERLIPIDAEMIA (ALSO COMPLETE THIS SECTION FOR PATIENTS WITH HYPERLIPIDAEMIA)

Motivation for a lipid-modifying agent for the treatment of hyperlipidaemia

The reimbursement of lipid-modifying therapy for primary prevention is reserved for patients with a greater than 20% risk of an acute clinical coronary event in the next 10 years. This funding decision is in accordance with local and international guidelines for the management of hyperlipidaemia.

Registered starting doses of lipid-modifying drugs and incremental dosage increases will be considered. Higher dosages will be considered on motivation. Kindly consider a less costly alternative, e.g. generic atorvastatin.

Requested drug and dose

Funding of ezetimibe is limited to those very high-risk patients not reaching an LDLC of ≤ 3.0 mmol/l despite at least two months' compliance with maximum dose standard therapy e.g. rosuvastatin titrated to 40mg daily.

Requests for the funding of ezetimibe must be accompanied by a motivation.

Risk factors (please indicate by ticking the appropriate box):

	✓	Comment
Smoker		
Diabetes type 1 with microalbuminuria or proteinuria (please supply supporting laboratory report)		
Ischaemic heart disease (e.g. angina, myocardial infarction [MI])		
Solid organ transplant (please supply relevant clinical information)		
Peripheral vascular disease (e.g. aortic aneurism)		
Stroke/transient ischaemic attacks (TIA)		
Chronic renal disease (please supply supporting laboratory report reflecting creatinine clearance)		
Renal artery stenosis		

History of fasting lipogram laboratory results (please indicate if the following results are pre-treatment or on treatment):

	Diagnosing lipogram (attach copy)	Lipogram on treatment (attach copy)
Date (DD/MM/YYYY)		
Lipid-modifying drug and dosage (please indicate mg/day in each column)		
Total cholesterol		
S-HDL		
S-LDL		
Total triglyceride		
TSH (where LDLC ≥ 4 mmol/l)		

Membership number

Doctor's practice number

5. PATIENTS WITH HYPERLIPIDAEMIA (CONTINUED)

Familial hyperlipidaemia (FH)

Diagnosed by an endocrinologist ☐ Yes ☐ No

Doctor's name

Practice number

Signs of FH
(e.g. tendon xanthomata)

Family history of premature atherosclerotic event in first-degree relative ☐ Yes ☐ No

Relative (e.g. father/sister)

Description (e.g. MI/stroke)

Age at time of event/death

Any other relevant clinical information about this patient that supports the diagnosis of hyperlipidaemia:

6. CHRONIC REGISTRATION CLINICAL CRITERIA

Chronic disease list (CDL) prescribed minimum benefit (PMB) conditions covered on the Health and Budget Plans	Benefit entry criteria requirements
Addison's disease	Diagnosis by a specialist physician, paediatrician, endocrinologist or by a State doctor
Asthma (adult)	Diagnosis confirmed by a GP or specialist
Asthma (child <7 years)	Diagnosis made or confirmed by specialist paediatrician
Bipolar mood disorder	A psychiatrist prescription. Benzodiazepines excluded on chronic benefit
Bronchiectasis	Diagnosis confirmed by a specialist (entry criteria for pre-existing conditions will apply e.g. COPD)
Cardiomyopathy	Diagnosis confirmed by a specialist physician
Chronic obstructive pulmonary disease (COPD)	Diagnosis confirmed by a GP or specialist. Copy of lung function test performed to American Thoracic Society (or similar) criteria demonstrating FEV1/FVC post-bronchodilator values <70% and FEV1 post-bronchodilator <80% of predicted as per risk equalisation fund criteria
Chronic renal (kidney) disease	Diagnosis confirmed by a nephrologist or specialist physician. Copy of lab results required: serum creatinine clearance value or a glomerular filtration rate estimate of eGFR ≤60ml/min/1.73m ²
Congestive cardiac (heart) failure	Diagnosis confirmed by a specialist physician
Coronary artery (heart) disease	Diagnosis confirmed by a specialist physician or cardiologist
Crohn's disease	Diagnosis by a specialist physician, paediatrician, surgeon, gastroenterologist or by a provider employed by a State hospital. Endoscopy report with histology results (colonic disease). Small bowel disease: imaging studies. Lab results: FBC; ESR and CRP; stool culture
Diabetes insipidus	Diagnosis by a specialist physician, paediatrician, neurologist, neurosurgeon or endocrinologist with the relevant ICD-10 code(s)
Diabetes mellitus type 1	Specialist initiation and confirmatory lab results: <ul style="list-style-type: none"> • HbA1c >6.5% • x2 random glucose >11mmol/l • x2 fasting blood >7mmol/l • x1 blood glucose >15mmol/l • GTT (fasting glucose >7mmol/l and/or two hours post-prandial glucose load >11.1mmol/l)
Diabetes mellitus type 2	Diagnosis confirmed by a GP or specialist physician and confirmatory lab results as above
Dysrhythmia	Diagnosis confirmed by a specialist physician
Epilepsy	New diagnosis confirmed by a specialist physician, neurologist, paediatrician or neurosurgeon
Glaucoma	Diagnosis confirmed by an ophthalmologist
Haemophilia	Diagnosis confirmed by a specialist physician. Copy of lab results of factor VIII or factor IX levels <5%

Membership number

Doctor's practice number

6. CHRONIC REGISTRATION CLINICAL CRITERIA (CONTINUED)

Chronic disease list (CDL) prescribed minimum benefit (PMB) conditions covered on the Health and Budget Plans (continued)	Benefit entry criteria requirements
Hyperlipidaemia (high cholesterol)	Diagnosis confirmed by a GP or specialist physician. Copy of lipogram results and documentation related to the risk assessment (Framingham Risk Score). Details of patient history: established vascular disease and details of any procedure performed e.g. angioplasty, stent etc. Details of family history from prescribing doctor (to include details of cardiovascular events in member's first-degree relatives, including age of onset)
Hypertension (high blood pressure)	Diagnosis by a GP or specialist physician
Hypothyroidism (underactive thyroid gland)	Diagnosis confirmed by a GP or specialist with relevant pathology
Multiple sclerosis (MS)	Diagnosis to be confirmed by a specialist physician, neurologist or neurosurgeon. Motivation and tick sheet to be filled in by a neurologist
Parkinson's disease	Diagnosis confirmed by a neurologist with relevant ICD-10 code(s)
Rheumatoid arthritis	Diagnosis confirmed by GP and a tick sheet to be completed, or diagnosis confirmed by a specialist physician, paediatrician or rheumatologist. We also require the following clinical information: Serum rheumatoid factor (RF), anti-CCP, ESR or C-reactive protein (CRP) and relevant X-rays
Schizophrenia	Diagnosis confirmed by a psychiatrist or paediatric psychiatrist
Systemic lupus erythematosus	Diagnosis by a specialist physician, paediatrician or rheumatologist
Ulcerative colitis	Diagnosis by a specialist physician, surgeon or gastroenterologist. Colonoscopy report with histology results. Lab results: FBC, ESR and CRP; stool culture

Non-CDL PMB conditions covered on the Health and Budget Plans	Further information/tests required
Aplastic anaemia	Specialist or GP prescription. Full blood count and iron studies not older than one month
Benign prostatic hyperplasia	Urologist prescription. GP prescription with PSA results
Cardiac arrhythmia	Cardiologist/physician's prescription
Cushing's disease	Specialist prescription
Endometriosis	Gynaecologist prescription. Diagnosis confirmed by laparoscopy report (histology)
Glomerular disease	Nephrologist/physician's prescription, relevant pathology and investigations
Hyperthyroidism	GP or specialist prescription with relevant pathology
Hypoparathyroidism	Specialist prescription with relevant pathology
Immune/idiopathic thrombocytopenic purpura (ITP)	Specialist prescription
Menopause/hormone replacement therapy (HRT)	Hormone profile for patients <50 years unless prescribed by a gynaecologist or hysterectomy done
Pancarditis	Cardiologist/physician's prescription
Paraplegia	Letter of motivation detailing clinical history from prescriber
Pemphigus	Dermatologist prescription
Pituitary adenoma	Specialist prescription
Polycystic ovarian syndrome	Gynaecologist motivation with scans/relevant pathology
Pulmonary hypertension	Cardiologist/physician prescription and diagnostic test results
Pulmonary interstitial fibrosis	Pulmonologists prescription and results of clinical investigations
Quadriplegia	Letter of motivation detailing clinical history from prescriber
Sarcoidosis	Specialist motivation
Stroke (cerebrovascular accident)/transient ischaemic attack (TIA)	Specialist prescription
Thromboangiitis obliterans (TAO)/Buerger disease	Specialist prescription
Tuberculosis (TB)	GP or specialist prescription and diagnostic test results
Valvular heart disease	Specialist prescription
Venous thromboembolism (VTE)	GP or specialist prescription

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6. CHRONIC REGISTRATION CLINICAL CRITERIA (CONTINUED)

Additional chronic conditions covered on the Health Plan only	Further information/tests required
Acne (severe)	Prescription from a dermatologist. Authorised for maximum six months at a time. Soaps and cleansers will not be allocated from the chronic benefit
Allergic rhinitis (hay fever)	Either nasal corticosteroids (preferred) or oral antihistamine
Alzheimer's disease	Psychiatrist/neurologist prescription and MMSE
Ankylosing spondylitis	Specialist prescription
Attention deficit hyperactivity disorder (ADHD)	Diagnosis confirmed by a paediatrician, psychiatrist or neurologist or a prescription from a GP together with a report from a psychologist
Cryoglobulinemia	Specialist motivation and relevant pathology
Cystic fibrosis	Specialist prescription
Depression	Initiation by a GP or psychiatrist. Psychiatrist prescription for second-line treatment. Limited to 12 months approval
Dermatomyositis	Specialist prescription
Dystonia	Neurologist prescription
Eating disorders	Psychiatrist prescription
Eczema/allergic dermatitis (severe)	A dermatologist prescription required for immunosuppressants. Benefits allocated for six months at a time
Embolism and thrombosis	Motivation required
Gastro-oesophageal reflux disease (GORD)	Gastroscopy results required
Huntington's disease	Neurologist motivation
Motor neuron disease	Specialist prescription
Myasthenia gravis	Specialist prescription
Narcolepsy	Specialist prescription
Obsessive compulsive disorder (OCD)	Psychiatrist prescription
Osteoporosis	DEXA scan results required indicating osteoporosis and fracture history if applicable
Paget's disease	DEXA scan results required, fracture and medication history if applicable
Psoriasis	GP or dermatologist initiation. A dermatologist prescription will be required for immunosuppressants
Scleroderma	Specialist prescription
Sjögren's syndrome	Specialist motivation and relevant pathology confirming the diagnosis
Systemic sclerosis	Specialist prescription
Tic disorders	Specialist prescription

Acknowledgement by examining doctor

Having conducted a personal examination and/or procured the tests and/or other diagnostic investigations referred to, I certify that the particulars are, to the best of my knowledge and belief, true and accurate. I acknowledge that Momentum Health will rely on such particulars when making any recommendations regarding the payment of ongoing/chronic medication to Imperial Motus Med.

Prescribing doctor's signature

Date

DD/MM/YYYY

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Medicine Risk Management Programme

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 Website www.imperialmotusmed.co.za

06/2025

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