GOLDEN ARROW
EMPLOYEES' MEDICAL BENEFIT FUND

APPLICATION FORM
CHRONIC RENAL DIALYSIS

We request your kind co-operation in completing this form. The information is necessary to enable the managed care team to process your patient's application for chronic renal management benefits. Once completed and signed, please submit this form along with the pathology reports and any other accompanying documentation by email to renalcare@goldenarrowmed.co.za. Thank you for taking the time to complete this application form. All information you provide will be treated as confidential. Once this request has been evaluated, you will receive further notification.

PLEASE USE BLOCK LETTERS FOR ALL SECTIONS

1. MEMBER AND PATIENT INFORMATION

MAIN MEMBER DETAILS

Membership number				Benefit option	
Title		Initials		ID number	
Full name and surname					
Email address					

PATIENT DETAILS

Dependant code					
Title		Initials		ID number	
Full name and surname					
Contact numbers		Home		Work	
		Cell phone			
Postal address					
				Postal code	
Email address					

2. PATIENT CONSENT

I understand that Golden Arrow Employees' Medical Benefit Fund 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 Renal Care Management Programme.

I understand that:

- Funding for this benefit is subject to meeting benefit entry criteria requirements as determined by the Fund.
- The benefit provides cover for therapy scientifically proven for my condition, which means that not all medication for the condition will automatically be covered.
- By registering for the 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 will only be effective once the Fund receives an application form that is completed in full.
- Payment to the healthcare professional for the completion of this form, on submission of a claim, will be subject to the Fund rules and where the member is a valid and active member at the service date of the claim.

Membership number | **Doctor's practice number**

2. PATIENT CONSENT (CONTINUED)

- 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 to 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 Golden Arrow Employees' Medical Benefit Fund 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 Fund, 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 any of my healthcare providers (e.g. pharmacist, pathologist, radiologist, treating doctor and/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 Fund and the administrator with my diagnosis and other relevant clinical information required to review and process my application.
5. I consent to the Fund 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 Fund 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 Fund 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 hereby certify that the information provided in this application is true and correct.

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

Date DD/MM/YYYY

3. MEDICAL PRACTITIONER'S INFORMATION

DOCTOR DETAILS

Practice number

Initials

Speciality

Surname

Contact numbers

Work

Cell phone

Postal address

Postal code

Email address

Membership number

Doctor's practice number

4. CLINICAL INFORMATION

Diagnosis and development of chronic renal disease

Date of diagnosis	DD/MM/YYYY
ICD-10 code(s)	

Attach pathology results (U&E and FBC)

Blood results	
eGFR	
Urea	
Creatinine	

Primary cause (disease) of the renal failure:

Describe clinical course and degree of severity with special reference to diabetes. Please include radiological and laboratory test results and provide a copy of the test results to the chronic renal management team, e.g. CT scans. Angiography digital vascular imaging should be done if indicated: current biochemical data should include FBC, U&E creatinine clearance, liver function, hepatitis screen and HIV.

Please describe the patient's general chronic condition, i.e. compliance with chronic medication, etc.:

Please describe the patient's present health status:

Membership number **Doctor's practice number**

4. CLINICAL INFORMATION (CONTINUED)

Please provide details of any other conditions that may disadvantage the patient:

Please provide a short history of the patient's psychological status and other relevant factors, such as drug abuse:

- ☐ Is family support available to the patient?
- ☐ Is the candidate compliant with treatment?
- ☐ Is the patient a suitable candidate for a kidney transplant?

Please provide reasons if the patient is **not** a suitable candidate for a kidney transplant:

Please include any additional pertinent information not covered above:

Membership number **Doctor's practice number**

4. CLINICAL INFORMATION (CONTINUED)

Treatment plan

☐ Haemodialysis ☐ APD ☐ CAPD ☐ Predialysis

Frequency of the dialysis	
Access type (e.g. fistula, graft, port, etc.)	
Dialysis unit name	
Dialysis facility practice number	

Chronic prescription (if not already submitted):

Name of medication	Strength/dosage	Frequency

Signature of treating medical practitioner

Date DD/MM/YYYY

Membership number

Doctor's practice number