

Chronic Illness Benefit application form 2025

This application form is to apply for the Chronic Illness Benefit and is only valid for 2025



Contact details

Tel: 0860 116 116 • PO Box 652509, Benmore 2010 • www.yourremedi.co.za

The latest version of the application form is available on www.yourremedi.co.za. Alternatively members can phone 0860 116 116 and health professionals can phone 0860 44 55 66.

Who we are

Remedi Medical Aid Scheme (referred to as 'the Scheme'), registration number 1430. This is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as 'the Administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. You (the member) must complete and sign Section 1 of this form.
3. Your doctor must complete Section 2, other relevant sections, sign section 7 and attach any test results, clinical reports or other information that we need to review the request. These requirements are shown in Section 3.
4. Please email this completed and signed form with supporting documents to chronicapplications@yourremedi.co.za or post it to Remedi, CIB Department, PO Box 652919, Benmore, 2010.

1. Patient's details

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|------------------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|---------------|---|---|---|---|---|---|---|---|--|
| First name(s) (as per identity document) | | | | | | | | | | | | | | | | | | | | | | |
| Surname | | | | | | | | | | | | | | | | | | | | | | |
| ID or passport number | | | | | | | | | | | | | Date of birth | D | D | M | M | Y | Y | Y | Y | |
| Membership number | | | | | | | | | | | | | | | | | | | | | | |
| Telephone | | | | | | | | | | | | | Cellphone | | | | | | | | | |
| Email | | | | | | | | | | | | | | | | | | | | | | |

The outcome of this application will be communicated to you by email.

I give consent to Discovery Health (Pty) Ltd and Remedi Medical Aid Scheme to use the above communication channel for all future communication.

I acknowledge that I have read and understood the conditions under "Member's acceptance and permission" on page 2.

| | | | | | | | | | | | | | | | | | | | | | |
|-------------------------------------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|------|---|---|---|---|---|---|---|---|
| Patient's signature | | | | | | | | | | | | | Date | Y | Y | Y | Y | M | M | D | D |
| (if patient is a minor, main member/legal guardian to sign) | | | | | | | | | | | | | | | | | | | | | |

Member's acceptance and permission

I give permission for my healthcare provider to provide Remedi Medical Aid Scheme and Discovery Health (Pty) Ltd with my diagnosis and other relevant clinical information required to review my application. I agree to give permission for you to collect and record information about my condition and treatment, this will also be used to develop registries. This data will be analysed, evaluated and used to measure clinical outcomes and make informed funding decisions.

I understand that:

- 1.1. Funding from the Chronic Illness Benefit is subject to meeting benefit entry criteria requirements as determined by Remedi Medical Aid Scheme.
- 1.2. The Chronic Illness Benefit provides cover for disease-modifying therapy only, which means that not all medicines for a listed condition is automatically covered by the Chronic Illness Benefit.
- 1.3. By registering for the Chronic Illness 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.
- 1.4. Funding for medicine from the Chronic Illness Benefit (CIB) will only be effective from when Remedi Medical Aid Scheme receives an application form that is completed in full. I can refer to the table in Sections 3 and 4 to see what additional information is required to be submitted for the condition for which I am applying.
- 1.5. A new Chronic Illness Benefit application form needs to be completed when applying for a new chronic condition.
- 1.6. If I am approved on the benefit, I need to let Remedi Medical Aid Scheme know when my treating doctor changes my treatment plan so my chronic authorisation/s can be updated. I can do this by emailing the new prescription to the email provided or asking my doctor or pharmacist to do this for me. Alternatively, my doctor can log onto HealthID to make the changes, provided that I have given consent. If I do not let Remedi Medical Aid Scheme and the Administrator know about changes to my treatment plan, my claims may not be paid from the correct benefit.
- 1.7. To make sure that my claims are paid from the correct benefit, the claims from my doctors must be submitted with the relevant ICD-10 diagnosis code(s). I must ask my doctor to include my ICD-10 diagnosis code(s) on the claims they submit and on the form that they complete when they refer me to pathologists and radiologists for tests. This will enable pathologists and radiologists to include the relevant ICD-10 diagnosis code(s) on the claims they submit, ensuring that my claims are paid from the correct benefit.

Consent for processing my personal information

I give the Scheme and the Administrator consent to have access to and process all information (including general, personal, medical or clinical information) that is relevant to this application. I understand that this information will be used for the purposes of applying for and assessing my funding request for Chronic Illness Benefits. I consent to the Scheme and the Administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical information) to my healthcare provider and to relevant third parties, to administer the Chronic Illness Benefits as well as undertake managed care interventions related to the chronic condition.

Consent withdrawal for your Chronic Illness Benefit (CIB)

Withdrawing consent for your general, personal, medical or clinical information to be accessed or shared with relevant third parties, means that you will no longer have access to funding from the applicable chronic illness benefits. Claims which would usually be funded from the chronic illness benefits will, once consent is withdrawn, be funded from other available benefits according to the rules of your option. Should you wish to continue with the consent withdrawal process, then please email chronicapplications@yourremedi.co.za.

2. Doctor's details (doctor to complete)

| | |
|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Name and surname | <input type="text"/> |
| Practice Number | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Speciality | <input type="text"/> |
| Telephone | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Email | <input type="text"/> |

The outcome of this application will be communicated to you by email.

3. The Chronic Disease List (CDL) conditions covered on Comprehensive, Classic and Standard Options

The following Chronic Disease List (CDL) conditions are covered by Remedi Medical Aid Scheme, in line with legislation.

Your cover is subject to benefit entry criteria. Approval on the Chronic Illness Benefit for your PMB CDL condition(s) offers cover for medicine and treatment baskets for the management of your condition(s). Please refer to the [website](#) for more information on what is covered on the benefit and how it is covered.

| Chronic disease list condition | Benefit entry criteria requirements |
|----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Addison's disease | Application form must be completed by a paediatrician (in the case of a child), endocrinologist or specialist physician |
| Asthma | None |
| Bipolar mood disorder | Application form must be completed by a psychiatrist |
| Bronchiectasis | Application form must be completed by a paediatrician (in the case of a child), pulmonologist or specialist physician |
| Cardiac failure | None |
| Cardiomyopathy | None |
| Chronic obstructive pulmonary disease (COPD) | 1. Please attach a lung function test (LFT) report which includes the FEV1/FVC post bronchodilator use 2. Please provide additional information when applying for oxygen including: a. arterial blood gas report off oxygen therapy b. number of hours of oxygen use per day |
| Chronic renal disease | 1. Application form must be completed by a nephrologist or specialist physician 2. Please attach a diagnosing laboratory report reflecting creatinine clearance |
| Coronary artery disease | None |
| Crohn's disease | Application form must be completed by a paediatrician (in the case of a child), gastroenterologist, specialist physician or surgeon |
| Diabetes insipidus | Application form must be completed by an endocrinologist or specialist physician |
| Diabetes type 1 | None |
| Diabetes type 2 | 1. Section 6 of this application form must be completed by the doctor 2. Please attach the diagnosing laboratory report |
| Dysrhythmia | None |
| Epilepsy | Application form for newly diagnosed patients must be completed by a neurologist, specialist physician or paediatrician (in the case of a child) |
| Glaucoma | Application form must be completed by an ophthalmologist |
| Haemophilia | Please attach the diagnosing laboratory report reflecting factor VIII or IX levels |
| HIV and AIDS (antiretroviral therapy) | Please do not complete this application form for cover for HIV and AIDS. To enrol or request information on our HIVCare Programme, please call 0860 116 116 |
| Hyperlipidaemia | 1. Section 4 of this application form must be completed by the doctor 2. Please attach the diagnosing laboratory report |
| Hypertension | None |
| Hypothyroidism | 1. Section 5 of this application form must be completed by the doctor 2. Please attach the diagnosing laboratory report |
| Multiple sclerosis (MS) | 1. Application form must be completed by a neurologist 2. Please attach a report from a neurologist for applications for beta interferon including: a. Relapsing – remitting history b. All MRI reports c. Extended disability status score (EDSS) |
| Parkinson's disease | Application form must be completed by a neurologist or specialist physician |
| Rheumatoid arthritis | Application form must be completed by a rheumatologist, paediatrician (in the case of a child) or specialist physician |
| Schizophrenia | Application form must be completed by a psychiatrist |
| Systemic lupus erthematosus | Application form must be completed by a paediatrician (in the case of a child), rheumatologist, nephrologist, pulmonologist or specialist physician |
| Ulcerative colitis | Application form must be completed by a paediatrician (in the case of a child), gastroenterologist, specialist physician or surgeon |

4. Application for hyperlipidaemia (to be completed by Doctor)

If the patient meets the requirements listed in either A, B, C or E below, hyperlipidaemia will be approved for funding from the Chronic Illness Benefit. Information provided in section D will be reviewed on an individual basis.

A. Primary Prevention

Please attach the diagnosing lipogram

Please supply the patient's current blood pressure reading / mmHg

Is the patient a smoker or has the patient ever been a smoker?

Yes No

Please use the Framingham 10-year Risk Assessment Chart as per the 2018 South African Dyslipidaemia Guidelines to determine the absolute 10-year risk of a coronary event and indicate:

Does the patient have a risk of 20% or greater

Yes

OR

Is the risk 30% or greater when extrapolated to age 60

Yes

B. Familial hyperlipidaemia

Please attach the diagnosing lipogram

Was the patient diagnosed with homozygous familial hyperlipidaemia and was the diagnosis confirmed by an endocrinologist or lipidologist?

Yes

Please attach supporting documentation.

OR

Was the patient diagnosed with heterozygous familial hyperlipidaemia and was the diagnosis confirmed by a specialist?

Yes

Please attach supporting documentation.

C. Secondary prevention

Please indicate what your patient has:

Diabetes type 2

Stroke

TIA

Coronary artery disease

Chronic kidney disease. Please supply the diagnosing laboratory report reflecting creatinine clearance

Peripheral arterial disease. Please supply the doppler ultrasound or angiogram

Diabetes type 1 with microalbuminuria or proteinuria

Any vasculitides where there is associated renal disease. Please supply the diagnosing laboratory report reflecting creatinine clearance

Solid organ transplant. Please supply the relevant clinical information in Section D

D. Please supply any other relevant clinical information about this patient that supports the diagnosis of hyperlipidaemia.

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E. Was the patient diagnosed with hyperlipidaemia more than five (5) years ago and the laboratory results are not available?

Yes

5. Application for hypothyroidism (to be completed by Doctor)

If the patient meets the requirements listed in either A, B, C, D or E below, hypothyroidism will be approved for funding from the Chronic Illness Benefit.

A. Thyroidectomy: Please indicate whether your patient has had a thyroidectomy Yes

B. Radioactive iodine: Please indicate whether your patient has been treated with radioactive iodine Yes

C. Hashimoto's thyroiditis: Please indicate whether your patient has been diagnosed with Hashimoto's thyroiditis Yes

D. Please attach the initial or diagnostic laboratory results that confirm the diagnosis of hypothyroidism, including TSH and T4 levels

Was the diagnosis based on the presence of **clinical symptoms and one of the following:**

A raised TSH and reduced T4 level Yes

OR

A raised TSH but normal T4 level and higher than normal thyroid antibodies Yes

OR

A raised TSH level of greater than or equal to 10 mIU/l on two (2) or more occasions at least three (3) months apart in a patient with a normal T4 level Yes

E. Was the patient diagnosed with hypothyroidism more than five (5) years ago and the laboratory results are not available? Yes

6. Application for diabetes type 2 (to be completed by Doctor)

If the patient meets the requirements listed in either A, B or C below, diabetes type 2 will be approved for funding from the Chronic Illness Benefit.

A. Please attach the initial or diagnostic laboratory results that confirm the diagnosis of diabetes type 2.

Please note that finger prick and point of care tests are not accepted for registration on the Chronic Illness Benefit.

Do these results show:

A fasting plasma glucose concentration ≥ 7.0 mmol/l Yes

OR

A random plasma glucose ≥ 11.1 mmol/l Yes

OR

A two hour post-load glucose ≥ 11.1 mmol/l during an oral glucose tolerance test (OGTT) Yes

OR

An HbA1C $\geq 6.5\%$ Yes

B. Is the patient a type 2 diabetic on insulin? Yes

C. Was the patient diagnosed with diabetes type 2 more than five (5) years ago and the laboratory results are not available? Yes

Important: please note that no exceptions will be made for patients being treated with Metformin monotherapy.

7. Medicine required (to be completed by Doctor)

To assist us in paying claims for the diagnosis of condition(s) from the correct benefits, please ensure that you include the **date when the condition was first diagnosed** in the table below.

| ICD-10 diagnosis code | Condition description | Date when condition was first diagnosed | Medicine name, strength and dosage | How long has this patient used this medicine? | |
|-----------------------|-----------------------|-----------------------------------------|------------------------------------|-----------------------------------------------|--------|
| | | | | Years | Months |
| | | | | | |
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Notes to Doctor

- 7.1. To assist us in paying claims from the correct benefits, please ensure that the date on which the condition was first diagnosed is stipulated in the table above.
- 7.2. Please ensure that the relevant ICD-10 diagnosis code(s) are used when you submit your claims to the Scheme to ensure payment from the correct benefit.
- 7.3. Please include the ICD-10 diagnosis code(s) when referring your patient to pathologists and radiologists. This will enable pathologists and radiologists to include this information on their claims and allow us to comply with legislation by paying Prescribed Minimum Benefits (PMB) claims correctly.
- 7.4. We will approve funding for generic medicine, where available, unless you have indicated otherwise.
- 7.5. Please submit all the requested supporting documents with this application to prevent delays in the review process.
- 7.6. Should you make changes to your patient's treatment plan, you need to let us know so that we can update their chronic authorisation/s. You can do this by emailing the new prescription to us or by logging onto HealthID to make the changes, provided that the patient has given consent. If you or your patient do not let us know about changes to the treatment plan, we may not pay claims from the correct benefit.

Doctor's signature

Date

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| D | D | M | M | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|