APPLICATION FORM
INTEGRATED CARE PROGRAMME

PLEASE USE BLOCK LETTERS FOR ALL SECTIONS

1. MEMBER AND PATIENT INFORMATION

TO BE COMPLETED BY THE APPLICANT

MAIN MEMBER DETAILS

Membership number	
Benefit option	☐ Select Plan ☐ Guardian Plan
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

Kindly indicate your preferred day and time for contact (Mon - Fri 9:00 - 16:00)

Postal address	
	Postal code
Email address	

PATIENT CONSENT

I understand that Transmed Medical Fund (Transmed) and Momentum Health (Pty) Limited, 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 Integrated Care 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.
- 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.

Membership number		Doctor's practice number	

1. MEMBER AND PATIENT INFORMATION (CONTINUED)

TO BE COMPLETED BY THE APPLICANT (CONTINUED)

PATIENT CONSENT (CONTINUED)

- 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 Transmed has appointed Momentum Health (Pty) Limited 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/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 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

2. MEDICAL PRACTITIONERS' INFORMATION

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

DOCTOR DETAILS

Practice number

Initials   Speciality

Surname

Contact numbers   Work   Fax

                         Cell phone

Postal address

                                        Postal code

Email address

Membership number   Doctor's practice number

2. MEDICAL PRACTITIONERS' INFORMATION (CONTINUED)

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER (CONTINUED)

ASSOCIATED SPECIALIST DETAILS

Practice number		Speciality	
Full name and surname			
Contact number			
Email address			

3. CLINICAL EXAMINATION

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

Gender ☐ Male ☐ Female ☐ Other | Weight ____ kg | Height ____ cm

Smoker ☐ Never ☐ Ex-smoker ☐ <10 per day ☐ >10 per day | Exercise ☐ Never ☐ <1 hour per week ☐ 1-3 hours per week ☐ >3 hours per week

Allergies ☐ Penicillin ☐ Aspirin ☐ Sulphonamides

Other _____

DETAILS OF DIAGNOSIS

Diagnosis	ICD-10 code(s)	Description	Date of diagnosis (DD/MM/YYYY)
Primary:			
Other:			

BLOOD GLUCOSE RESULTS

HbA$_{1c}$
Reading 1 ____ %   Test date ____ (DD/MM/YYYY)
Reading 2 ____ %   Test date ____
Reading 3 ____ %   Test date ____

Blood glucose
Reading 1 ____ mmol/L   Test date ____ (DD/MM/YYYY)
Reading 2 ____ mmol/L   Test date ____
Reading 3 ____ mmol/L   Test date ____

Membership number _____   Doctor's practice number _____

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER (CONTINUED)

CARDIAC RESULTS

Blood pressure

Reading 1	_____ / _____ mmHg	Test date	_____	(DD/MM/YYYY)
Reading 2	_____ / _____ mmHg	Test date	_____	
Reading 3	_____ / _____ mmHg	Test date	_____	

RESPIRATORY RESULTS

Forced expiratory volume (FEV1%)

Reading 1	_____ %	Test date	_____	(DD/MM/YYYY)
Reading 2	_____ %	Test date	_____	
Reading 3	_____ %	Test date	_____	

Peak flow

Reading 1	_____ %	Test date	_____	(DD/MM/YYYY)
Reading 2	_____ %	Test date	_____	
Reading 3	_____ %	Test date	_____	

LIPOGRAM RESULTS

Total cholesterol

Reading 1	_____ mmol/L	Test date	_____	(DD/MM/YYYY)
Reading 2	_____ mmol/L	Test date	_____	
Reading 3	_____ mmol/L	Test date	_____	

Low-density lipoproteins (LDL)

Reading 1	_____ mmol/L	Test date	_____	(DD/MM/YYYY)
Reading 2	_____ mmol/L	Test date	_____	
Reading 3	_____ mmol/L	Test date	_____	

Triglycerides (TG)

Reading 1	_____ mmol/L	Test date	_____	(DD/MM/YYYY)
Reading 2	_____ mmol/L	Test date	_____	
Reading 3	_____ mmol/L	Test date	_____	

PRESCRIBED MINIMUM BENEFITS

If your patient has one of more of the following chronic conditions, they may qualify for additional services. Please indicate which condition(s) your patient have.

- [ ] Addison's disease
- [ ] Asthma
- [ ] Bipolar mood disorder
- [ ] Bronchiectasis
- [ ] Cardiac failure
- [ ] Cardiomyopathy disease
- [ ] Chronic obstructive pulmonary disorder (COPD)
- [ ] Chronic renal disease
- [ ] Coronary artery disease
- [ ] Crohn's disease
- [ ] Diabetes insipidus
- [ ] Diabetes mellitus type 1
- [ ] Diabetes mellitus type 2
- [ ] Dysrhythmias
- [ ] Epilepsy
- [ ] Glaucoma
- [ ] Haemophilia
- [ ] Hyperlipidaemia (high cholesterol)
- [ ] Hypertension (high blood pressure)
- [ ] Hypothyroidism
- [ ] Multiple sclerosis
- [ ] Parkinson's disease
- [ ] Rheumatoid arthritis
- [ ] Schizophrenia
- [ ] Systemic lupus erythematosus
- [ ] Ulcerative colitis

If your patient is at risk of being HIV positive, or has been diagnosed as a person living with HIV/AIDS, please advise them to register on the HIV **YourLife** Programme on 0860 109 793 (all calls are confidential).

Membership number _____   **Doctor's practice number** _____

3. CLINICAL EXAMINATION (CONTINUED)

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER (CONTINUED)

Additional information relevant to your patient's condition(s):

4. CHRONIC MEDICATION APPLICATION

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

Please complete this application for chronic medication, if applicable to the patient.

Please note: Prescribed Minimum Benefit rules, chronic disease lists and medication formularies applicable to your benefit option will apply. As per the requirements of the Government Risk Equalisation Fund (REF), in order to register patients on the Chronic Medicine Risk Management Programme, documentation from a relevant specialist and/or test results verifying the diagnosis, is required for, but is not limited to, the following:

- Chronic obstructive airways disease: Documentation of lung function tests (most recent)
- Chronic renal failure: Documentation of creatinine clearance or Glomerular Filtration Rate (GFR) estimate (most recent)
- Haemophilia: Factors VIII and IX blood levels
- Hyperlipidaemia: Pre-treatment lipogram
- Diabetes type 1 or 2 and/or second- or third-line drugs: HbA1c and motivation

MEDICATION PRESCRIBED

ICD-10 code(s)	Detailed diagnosis	Date of diagnosis (DD/MM/YYYY)	Medication name (trade name or generic equivalent)	Strength (e.g. 50mg)	Directions (e.g. 2tds)	Date medication started (DD/MM/YYYY)

Membership number _____

Doctor's practice number _____

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER (CONTINUED)

Additional information/motivation:

MEDICATION STOPPED

ICD-10 code(s)	Diagnosis	Medication 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 _____

10/2025

INTEGRATED CARE PROGRAMME

Telephone 0800 225 151   **Email** disease@transmed.co.za   **Website** www.transmed.co.za