



## Chronic medicine application form

Enquiries: 086 0100 678

Email address: medicineapp@medihelp.co.za

www.medihelp.co.za

### Section 1: To be completed by the patient

#### Details of main member

Title \_\_\_\_\_

ID-number \_\_\_\_\_

Surname \_\_\_\_\_

Initials \_\_\_\_\_

Plan \_\_\_\_\_

Member number \_\_\_\_\_

#### Details of patient

Title \_\_\_\_\_

ID-number \_\_\_\_\_

Surname \_\_\_\_\_

Initials \_\_\_\_\_

Telephone number (H) 

--	--	--

--	--	--	--	--	--

Gender 

Male	Female
------	--------

Cell phone number 

--	--	--	--	--	--

Telephone number (W) 

--	--	--

--	--	--	--	--	--	--

Email address \_\_\_\_\_

Smoking 

Yes	No
-----	----

Weight \_\_\_\_\_

Physical activity 

Low	Moderate	Vigorous
-----	----------	----------

Height \_\_\_\_\_

Consent of patient

I give permission to Medihelp to have access to and process all information that is relevant to this application. The information supplied will be used for the purposes of this chronic medicine application form and related matters.

I understand and declare that my application shall be voided should any information supplied by me be false or incomplete. I grant permission to my doctor to state the diagnosis of my medical condition on this form and understand that the information on this application form will remain confidential at all times. I understand that authorisation is subject to clinical entry criteria and algorithms as determined by Medihelp.

Signature of patient

(parent/guardian if minor)

Date 

y	y	y	y	m	m	d	d
---	---	---	---	---	---	---	---

### Section 2: To be completed by the medical doctor

#### Information of medical doctor

Initials and surname \_\_\_\_\_

Type of practitioner (eg general practitioner) \_\_\_\_\_

Practice number \_\_\_\_\_ Telephone number \_\_\_\_\_

Email address \_\_\_\_\_

I declare that, to the best of my knowledge, all the information provided in this application is true and accurate. I acknowledge that Medihelp can only make informed reimbursement decisions if supplied with all relevant information about the patient's condition.

Signature

Date 

y	y	y	y	m	m	d	d
---	---	---	---	---	---	---	---

## Required criteria for approval of PMB chronic medicine benefits

Members can apply for **PMB medicine** benefits for the following 26 chronic conditions on the Chronic Diseases List (CDL). It is imperative that a patient **meets the criteria** as stipulated in the application form when applying for benefits for these conditions. Please note that cover is subject to clinical entry criteria and protocols. The following details are provided for your information only and should kindly not be returned to Medihelp with your application. In the case of **MedMove!, MedVital Elect, MedAdd Elect, and MedPrime Elect members**, the relevant formulary must be consulted before medicines for PMB conditions are prescribed. Medihelp reserves the right to request additional information should this be required for specialised medicine or out-of-protocol medicine requests.

PMB condition	Requirements for all benefit options
Addison's disease	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by an <b>endocrinologist, specialist physician, or paediatrician</b></li> </ul>
Asthma	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a registered medical doctor</li> </ul>
Bipolar disorder	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a <b>psychiatrist</b> in case of a <b>new application</b></li> <li>If diagnosed by a <b>general practitioner</b>, confirmation of the diagnosis by a <b>psychiatrist</b> within six months of a <b>new application</b></li> </ul>
Bronchiectasis	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a <b>pulmonologist, specialist physician or paediatrician</b></li> </ul>
Cardiac failure	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a registered medical doctor</li> </ul>
Cardiomyopathy	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a <b>cardiologist, specialist physician, or paediatrician</b></li> </ul>
Chronic obstructive pulmonary disease (COPD)	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a registered medical doctor</li> <li>A lung function test indicating both the FEV1/FVC and FEV1 <b>post-bronchodilator</b> values</li> </ul>
Chronic renal disease	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a <b>nephrologist, specialist physician, or paediatrician</b> in case of a <b>new application</b></li> <li>Diagnostic serum creatinine clearance results or glomerular filtration rate (GFR) in case of a <b>new application (please attach pathology results)</b></li> <li>Haemoglobin results if applying for erythropoietin</li> </ul>
Coronary artery disease	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a registered medical doctor</li> </ul>
Crohn's disease	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a <b>gastroenterologist, specialist physician, surgeon, or paediatrician</b></li> </ul>
Diabetes insipidus	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by an <b>endocrinologist</b></li> </ul>
Diabetes mellitus type 1	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a registered medical doctor</li> </ul>
Diabetes mellitus type 2	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a registered medical doctor</li> <li>Diagnostic fasting plasma glucose, random blood glucose, two-hour post-load glucose or glycated haemoglobin A1c (HbA1c) results in case of a <b>new application (please attach pathology results which confirmed your initial diagnosis)</b></li> <li>Complete the <b>application form for diabetes mellitus type 2 in section 4</b></li> </ul>
Dysrhythmia	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a registered medical doctor</li> </ul>
Epilepsy	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a <b>neurologist, specialist physician, paediatrician, or geriatrician</b> in case of a <b>new application</b></li> </ul>
Glaucoma	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by an <b>ophthalmologist</b></li> </ul>
Haemophilia	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a registered medical doctor</li> <li>Diagnostic results of factor VIII or IX levels in case of a <b>new application</b></li> </ul>
Hyperlipidaemia	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by any registered medical doctor</li> <li>Complete the <b>application form for hyperlipidaemia in section 5</b></li> <li><b>Fasting diagnostic lipogram</b>, including the total cholesterol, HDL, triglyceride and LDL values</li> </ul>
Hypertension	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a registered medical doctor</li> </ul>
Hypothyroidism	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a registered medical doctor</li> <li>Complete the <b>application form for hypothyroidism in section 6</b></li> <li>Diagnostic TSH and FT4 pathology results in case of a <b>new application (please attach diagnostic pathology results)</b></li> </ul>
Multiple sclerosis	<ul style="list-style-type: none"> <li>ICD-10 code and clinical diagnostic report by a <b>neurologist</b>, supported by MRI findings</li> </ul>
Parkinson's disease	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a <b>neurologist or specialist physician</b></li> </ul>
Rheumatoid arthritis	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a <b>rheumatologist, specialist physician, or paediatrician</b></li> </ul>
Schizophrenia	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a <b>psychiatrist</b></li> </ul>
Systemic lupus erythematosus	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a <b>rheumatologist, pulmonologist, nephrologist, specialist physician, or paediatrician</b></li> </ul>
Ulcerative colitis	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a <b>gastroenterologist, specialist physician, surgeon, or paediatrician</b></li> </ul>

## Required criteria for approval of chronic medicine benefits - MedPlus and MedElite

The following chronic conditions are also covered for MedPlus and MedElite members only. Please note that cover is subject to clinical entry criteria and protocols.

Chronic condition	Requirements (MedPlus and MedElite only)
Acne	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a <b>dermatologist</b></li> </ul>
Allergic rhinitis	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a registered medical doctor</li> </ul>
Alzheimer's disease	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a <b>neurologist</b> or <b>psychiatrist</b>, submitted with the results of a Mini Mental State Examination (MMSE), a Short Test of Mental Status (STMS), or a Montreal Cognitive Assessment (MoCA)</li> </ul>
Ankylosing spondylitis	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a <b>rheumatologist</b>, <b>specialist physician</b>, or <b>paediatrician</b></li> </ul>
Attention-deficit disorder with or without hyperactivity (ADHD)	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a <b>psychiatrist</b>, <b>neurologist</b>, or <b>paediatrician</b> in case of a new application</li> </ul>
Blepharospasm	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a <b>neurologist</b> or <b>ophthalmologist</b>, with a motivation</li> </ul>
Cystic fibrosis	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a <b>pulmonologist</b>, <b>specialist physician</b>, or <b>paediatrician</b></li> </ul>
Dermatitis	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a <b>dermatologist</b> if combination therapy is prescribed</li> </ul>
Gastro-oesophageal reflux disease	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a registered medical doctor</li> <li>Gastroscopy report not older than 12 months to confirm diagnosis</li> </ul>
Generalised anxiety disorder	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a <b>psychiatrist</b></li> </ul>
Gout	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a registered medical doctor</li> </ul>
Major depression	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a registered medical doctor</li> </ul>
Ménière's disease	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by an <b>ear, nose and throat specialist</b></li> </ul>
Migraine	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a registered medical doctor for first-line treatment</li> <li><b>Second-line treatment</b> will be considered if prescribed by a <b>neurologist</b></li> </ul>
Motor neuron disease	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a <b>neurologist</b></li> </ul>
Myasthenia gravis	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a <b>neurologist</b></li> <li>Diagnostic acetylcholine-receptor antibody test (attach the diagnostic pathology report)</li> <li>Date of initial diagnosis</li> </ul>
Narcolepsy	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a <b>neurologist</b> or <b>psychiatrist</b></li> </ul>
Neuropathic pain	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a registered medical doctor</li> </ul>
Obsessive-compulsive disorder	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a <b>psychiatrist</b></li> </ul>
Osteo-arthritis	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a registered medical doctor</li> </ul>
Osteoporosis	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a registered medical doctor</li> <li>Bone mineral density test result (only a <b>DEXA scan</b> is accepted) and an indication of the relevant risk factors</li> </ul>
Post-traumatic stress disorder	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a <b>psychiatrist</b></li> </ul>
Psoriasis	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a <b>dermatologist</b></li> </ul>
Psoriatic arthritis	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a <b>rheumatologist</b>, <b>specialist physician</b>, or <b>paediatrician</b></li> </ul>
Pulmonary interstitial fibrosis	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a <b>pulmonologist</b></li> </ul>
Sjögren's syndrome	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a <b>rheumatologist</b>, <b>specialist physician</b>, or <b>paediatrician</b></li> </ul>
Trigeminal neuralgia	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a <b>neurologist</b></li> </ul>
Urinary incontinence	<ul style="list-style-type: none"> <li>ICD-10 code and diagnosis by a registered medical doctor</li> </ul>

Surname and initials of main member

Name of patient \_\_\_\_\_

Member number

--	--	--	--	--	--	--

### **Section 3: To be completed by the medical doctor**

## Instructions

1. Complete one application form per patient.
2. **Incomplete or old application forms will not be processed. This application form is only valid for 2026.**
3. If the medicine for a **registered condition** changes, a new script and ICD-10 codes must be sent to Medihelp.
4. Email the completed and signed application form to **medicineapp@medihelp.co.za**.
5. Registration with Medihelp or changes to an authorisation schedule will only be valid from the date of approval. **Authorisation schedules will under no circumstances be backdated.**
6. If you have any enquiries, please call Medihelp's client care centre on **086 0100 678**.
7. The Client Care centre is available Mondays to Thursdays from 07:00 to 17:00 and Fridays from 08:00 to 16:00.
8. Clinical queries from medical doctors will be handled from Mondays to Thursdays from 07:30 to 16:00 and Fridays from 08:00 to 16:00. Only queries about conditions already registered with Medihelp will be handled telephonically.

**General biometric information (to be completed for all applicants/dependants)**

## Blood pressure

### Total cholesterol

fasting	non-fasting
---------	-------------

### Glucose reading

fasting non-fasting

## Details of medicine

Please remember to attach the applicable pathology and/or diagnostic reports, as indicated in the list of requirements. Reports must be clear and readable. Please refer to the formulary for MedMove! and the formulary for MedVital Elect, MedAdd Elect, and MedPrime Elect when prescribing medicine for members of these plans.

Please note that cover is subject to clinical entry criteria and protocols.

Name of attending doctor

Practice number

Type of practitioner (eg cardiologist)

1. **What is the primary purpose of the study?** (Please check one box)

Signature of medical doctor

1. **What is the primary purpose of the study?**

Date y y y y m m d d

Surname and initials of main member \_\_\_\_\_

Name of patient \_\_\_\_\_

Member number

--	--	--	--	--	--	--

**Section 4: Diabetes mellitus type 2**

Please attach all pathology reports confirming the values mentioned on the application.

On therapy

Yes	No
-----	----

Date of diagnosis \_\_\_\_\_

Diagnostic fasting blood glucose value \_\_\_\_\_

or

Diagnostic HbA1c value \_\_\_\_\_

Current HbA1c value (not older than 1 month) \_\_\_\_\_

**Medicine history**

Medicine	Dosage and strength	Duration of treatment	Reasons for discontinuation

Motivation if treatment other than metformin, sulphonylurea, or DPP-4 inhibitors is prescribed

---



---



---

Please specify the medicine you are applying for

---



---



---

ICD-10 code

--

Surname and initials of main member \_\_\_\_\_

Name of patient \_\_\_\_\_

Member number \_\_\_\_\_

--	--	--	--	--	--	--

**Section 5: Hyperlipidaemia**

Please supply the baseline lipogram values. If the baseline values are not available, confirm that the lipogram was done on therapy and specify the medicine currently being used.

Please attach the pathology report to this application.

Baseline lipogram  or On therapy 

Total cholesterol \_\_\_\_\_

Triglycerides \_\_\_\_\_

HDL \_\_\_\_\_

LDL \_\_\_\_\_

If on therapy, indicate the medicine used when the attached lipogram was done or values were determined.

Duration of therapy, if on therapy \_\_\_\_\_

Age when diagnosed \_\_\_\_\_

Systolic blood pressure reading \_\_\_\_\_

Is the patient on treatment for hypertension?

Yes	No
-----	----

Does the patient smoke?

Yes	No
-----	----

**Positive family history of myocardial infarction in:**

- First-grade male blood relative (father/brother) < 55 years
- First-grade female blood relative (mother/sister) < 65 years

Yes	No
Yes	No

**Familial hyperlipidaemia:**

Diagnosed by an endocrinologist?

Yes	No
-----	----

Name of endocrinologist: \_\_\_\_\_

**Please indicate if the patient has/had the following conditions and supply the pathology results, where applicable.**

- Chronic renal disease- attach the diagnostic pathology results indicating the serum creatinine clearance results or the glomerular filtration rate (GFR) if not yet registered with Medihelp.
- Coronary artery disease
- Type 1 diabetes with demonstrated microalbuminuria or proteinuria – attach the pathology results
- Type 2 diabetes – attach the **diagnostic pathology results** if not yet registered with Medihelp. If not available, attach the most recent pathology results with confirmation that the patient is on therapy, and state the duration of the therapy.

Yes	No

Therapy duration \_\_\_\_\_

- Stroke
- Transient ischemic attack (TIA)

Yes	No
Yes	No

Please specify the medicine for which you are applying \_\_\_\_\_

ICD-10 code

Surname and initials of main member \_\_\_\_\_

Name of patient \_\_\_\_\_

Member number

--	--	--	--	--	--	--

**Section 6: Hypothyroidism**

Please supply the pathology report with the baseline TSH and FT4 values. If the baseline values are not available, confirm that the pathology was done on therapy.

New diagnosis  or On therapy 

Please indicate if the following is applicable to this patient:

- TSH-value raised (in case of a new diagnosis, please attach the pathology report to this application)
- Hashimoto's thyroiditis
- Thyroidectomy
- Radioactive iodine treatment

Please specify the medicine for which you are applying \_\_\_\_\_

ICD-10 code