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commed
COMMUNITY MEDICAL AID SCHEME

REGISTRATION FORM FOR PMB CHRONIC DISEASE LIST CONDITIONS (CDL)

(to Comply with the Risk Equalisation Fund (REF) Criteria) and other Chronic Conditions

COMPLETE THE RELEVANT SECTIONS AND RETURN ALL PAGES to
Private Bag X146, Halfway House, 1685
or faxed to 011 290 5084
NB: Please complete one application form per Patient

SECTION 1 Member Information

Date D D M M Y Y

OPTION ☐ De Luxe ☐ Standard ☐ Fundamental

Membership Number

ID Number

Initials and Surname

Work Telephone number

Home Telephone number

Cellular number

Fax number

E-mail address

Language

Postal Address

Code

SECTION 2 Patient Information

Dependant Code

Patient ID Number

Initials and Surname

Work Telephone number

Home Telephone number

Cellular number

Gender (Male / Female)

Date of Birth D D M M Y Y

Postal Address
(if different from member)

Code

SECTION 3 Doctor Information

Initials and Surname

Doctor's Speciality

Practice Number

Work Telephone number

Fax number

Cellular number

E-mail address

CLINICAL ENTRY CRITERIA FOR THE PMB-CDL CONDITIONS TO BE COMPLETED BY THE TREATING PHYSICIAN:

In order for a patient to qualify for the PMB benefit and to fulfil the requirements of the Risk Equalisation Fund (REF), the treating physician must supply the relevant information per disease condition on the following pages

The Physician's signature is required on each page to confirm the CDL condition together with the appropriate ICD-10 code.

Failure to complete the application, with the relevant signatures from the patient and the treating physician, as well as providing the required information, will result in non-registration of the condition.

SECTION 4 Declaration

I declare and understand that this application shall be null and void if any information supplied by me should be false or incomplete In which case I will repay all monies paid to me (or on my behalf) by the scheme for benefits received in the treatment of any of the disease conditions ticked.

I give my irrevocable consent to any medical doctor, person or organization that may possess, or come into possession of any medical information to disclose this information to the scheme, to the extent permitted by law.

_____
SIGNATURE (Principal Member)

Signed at _____ on this _____ day of _____ 20 ____

SECTION 5 Patient Details

Medical Scheme		Patient Initials and Surname	
Member Number		Patient Dependent Code	

CARDIOVASCULAR

Disease	√	ICD-10 Code	Clinical Entry Criteria / Remarks
Cardiac Failure			
Cardiomyopathy			
Coronary Artery Disease			
Dysrhythmias			
Hyperlipidaemia • Require supporting Documentation			

Risk Factors: (Please indicate where applicable)

Family History		Hypertension		Anqina/Myocardial infarction		Anqioplasly/Stent	
Cerebrovascular Accident (CVA)		Transient Ischaemic Attack		Peripheral Vascular Disease			

ENDOCRINOLOGY

Disease	√	ICD-10 Code	Clinical Entry Criteria / Remarks
Addison's Disease			
Diabetes Insipidus			
Diabetes Mellitus 1			
Diabetes Mellitus 2			
Hypothyroidism			

RESPIRATORY

Disease	√	ICD-10 Code	Clinical Entry Criteria / Remarks
Asthma			
Bronchiectasls			
Chronic Obstructive Pulmonary Disease (COPD) • Require supporting Documentation			

AUTO IMMUNE DISEASES

Disease	√	ICD-10 Code	Clinical Entry Criteria / Remarks
Multiple Sclerosis			• Please note that confirmation of diagnosis is required from a Neurologist. Neurologist Practice Number:
Systemic Lupus Erythematosus			

SECTION 5 cont. Patient Details

AUTO IMMUNE DISEASES (Continued)			
Disease	**√**	**ICD-10 Code**	**Clinical Entry Criteria / Remarks**
Rheumatoid Arthritis			• Please tick the appropriate initial symptoms:
			Morning stiffness lasting at least one hour before maximal improvement, for at least 6 consecutive weeks.
			Soft tissue swelling or effusion, observed by a physician, in at least three of the following joint areas (right or left): proximal interphalangeal (PIP), metacarpophalangeal (MCP), wrist, elbow, knee, ankle or metatarsophalangeal (MTP) joints, for at least 6 consecutive weeks
			Swelling or effusion, observed by a physician, in the proximal interphalangeal metacarpophalangeal, or wrist joints, for at least 6 consecutive weeks
			Symmetrical (right and left sides) swelling or fluid in the joints mentioned in point 2, observed by a physician, for at least 6 consecutive weeks
			Subcutaneous nodules over bony prominences or extensor surfaces, or in juxta articular regions, observed by a physician
			Demonstration of serum rheumatoid factor (RF) detected by any method that has been positive in less than 5% of control subjects.
			Radiographic evidence in the hands or wrists of articular erosions or osteopenia in or around the affected joints

INFLAMMATORY BOWEL DISEASE			
Disease	**√**	**ICD-10 Code**	**Clinical Entry Criteria / Remarks**
Crohn's Disease			
Ulcerative Colitis			

CENTRAL NERVOUS SYSTEM DISEASES			
Disease	**√**	**ICD-10 Code**	**Clinical Entry Criteria / Remarks**
Bipolar Mood Disorder			• Please note that confirmation of diagnosis is required from a Psychiatrist Psychiatrist Practice Number:
Epilepsy			
Parkinson's Disease			
Schizophrenia			• Please note that confirmation of diagnosis is required from a Psychiatrist Psychiatrist Practice Number:

OTHER DISEASES			
Disease	**√**	**ICD-10 Code**	**Clinical Entry Criteria / Remarks**
Chronic Renal Disease • Require supporting Documentation			
Glaucoma			
Haemophilia			

Prescribing Doctor Signature:		Date:	
Patient Signature:			

HIV/AIDS
Please contact Lifesense on 0860 50 60 80 to enrol into the disease management programme

ONCOLOGY
Please contact Allcare Administrators on 011 290 6200 or 011 290 6307 to enrol into the disease management programme

SECTION 5 cont. Patient Details

OTHER CHRONIC CONDITIONS

Please note: The following conditions may be reimbursed from the chronic benefit for the COMMED Deluxe option.
The COMMED Standard and Fundamental options do not have a separate chronic benefit.
• Additional information may be required

Disease	√	ICD-10 Code	Clinical Entry Criteria / Remarks
ADHA (in children)			• Please note that confirmation of diagnosis is required from a Phychiatrist Psychiatrist Practice Number:
Allergic Rhinitis			
Ankyloslng Spondylitis			
Chronic Depression			
Cushing's disease			
Endocarditis Prohylaxis			
Endometriosis			• Must be prescribed by a gynaecologist
Gastro Oesophageal Reflux Disease			• Gatroscopy required
Gout			
Hypoparathyroidism			
Menopause (Hormone Replacement Therapy)			
Organ Transplant			
Osteo-arthritis			
Osteoporosis			• Bone mineral density report required
Paget's Disease			
Pituitary Adenoma			
Prostatic Hypertrophy (Benign)			• Must be prescribed by urologist
Psoriasis			

Medicine Prescribed:

Prescribing Doctor Signature:	
Date:	