Regular Force Medical Continuation Fund

Tel: 012 679 4200 | Fax: 012 679 4460 | chronicregistration@rfmcf.co.za | PO Box 3799, Pretoria, 0001

CHRONIC CONDITION APPLICATION FORM

1. Complete and sign **Section A.**
2. Take the Chronic Condition Application Form to your doctor to complete **Section B and C.**
3. A separate form must be completed for each patient.
4. Once the form is completed, your treating doctor/yourself must email the completed form to **chronicregistration@rfmcf.co.za**

Section A: Patient Information

Title/Rank			
Surname		**Initials**	
Full First Name/s			
Gender (M=Male; F=Female)		**Date of Birth**	D D M M Y Y Y Y
R.S.A Identity Number			
VPA Number/ Force number			
Physical Address (Include Suburb, Town, Province)			
		Postal Code	
Telephone Number: Home		**Cell Number**	
Email Address			

Permission is given to the RFMCF to discuss your condition with your doctor or other relevant 3rd parties to assist with managing your chronic condition(s).

I, the dependant of the membership profile, hereby give consent to the Principal Member to receive information with regards to my Chronic Disease Risk Management.

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Dependant / Parent / Guardian Signature **Date**

Section B: This section must be filled out by your Treating Doctor:

Treating Doctor - name and surname:	
Speciality if applicable:	
Military facility practicing in (if applicable):	
BHF/MP number:	
Telephone number:	
Signature:	

TAKE NOTE: Use tariff code 0199 to claim for the completion of the Chronic Condition Application Form.

Section C: This section must be filled out by your treating Doctor:

Condition		Tick Box	Relevant Clinical results for example Blood Pressure, BMI, HbA1c, Lipogram, clinical history and risk factors for example smoking and family history	Medicines
1	Addison's Disease			
2	Asthma			
3	Bipolar Mood Disorder			
4	Bronchiectasis			
5	Cardiac Failure			
6	Cardiomyopathy			
7	Chronic Obstructive Pulmonary Disease (COPD)			
8	Chronic Renal Failure			
9	Coronary Artery Disease			
10	Crohn's Disease			
11	Diabetes Insipidus			
12	Diabetes Mellitus Type 1			
13	Diabetes Mellitus Type 2			

Section C: This section must be filled out by your treating Doctor-continued.

Condition		Tick Box	Relevant Clinical results for example Blood Pressure, BMI, HbA1c, Lipogram, clinical history and risk factors for example smoking and family history	Medicines
14	Dysrhythmias			
15	Epilepsy			
16	Glaucoma			
17	Haemophilia (A + B)			
18	HIV/Aids			
19	Hyperlipidemia			
20	Hypertension			
21	Hypothyroidism			
22	Major Depression			
23	Multiple Sclerosis			
24	Parkinson’s Disease			
25	Rheumatoid Arthritis			
26	Schizophrenia			
27	Systemic Lupus Erythematosus			
28	Ulcerative Colitis			

Section D: Chronic Registration

1. Member's acceptance and permission

1.1 I give my healthcare provider permission to provide the Regular Force Medical Continuation Fund and the administrator with my diagnosis and other relevant clinical information required to review my application.
1.2 I agree with my information being used to develop my health record. This means that you permit us to collect and record information about your condition and treatment. This data will be analysed, evaluated, and used to measure clinical outcomes and make informed funding decisions.
1.3 By registering for the Disease Risk Management Programme, I agree that my condition may be subject to disease management interventions and periodic review. This may include access to my medical records.
1.4 I acknowledge that an application form needs to be completed when applying for a new chronic condition.
1.5 I agree that after the initial registration on the Disease Risk Management Programme, I will inform the Fund when my treating doctor changes my treatment plan to update my chronic authorisation/s.
1.6 To ensure that my claims are linked to the Disease Risk Management Programme, I will ensure that my healthcare providers' claims are submitted with the relevant ICD-10 diagnosis code(s).

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2. Consent for processing my personal information.

2.1 I give the Fund and the administrator consent to have access to and process all information (including general, personal, medical, or clinical information) relevant to this application.
2.2 I consent to the Fund and the administrator disclosing, from time to time, the information supplied to them (including general, personal, medical, or clinical information) to my healthcare provider and to relevant third parties to administer the Disease Risk Management Programme as well as undertake managed care interventions related to the chronic condition.

3. Notes to doctors

3.1 Please ensure that the relevant ICD-10 diagnosis code(s) are used when you submit your claims to the Fund to ensure the services links to the Disease Risk Management Programme for effective clinical management.
3.2 Please include the ICD-10 diagnosis code(s) when referring your patient to the pathologists and radiologists. This will enable the pathologists and radiologists to include this information on their claims
3.3 The RFMCF promotes the use of generic medicine and will approve funding for generic medicine, where available unless you have indicated otherwise.
3.4 Please submit all the requested supporting documents with this application to prevent delays in the review process.
3.5 Should you make changes to your patient's treatment plan, you need to let us know to update their treatment plan. You can do this by e-mailing the new prescription to us, 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 link claims to the Disease Risk Management Programme for effective clinical management.

Signature of Principal Member		Print Name and Surname of Principal Member	
Date	D D — M M — 2 0 D D		