Regular Force
Medical Continuation Fund

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

SELF REGISTRATION CHRONIC FORM

Disease Risk Management (DRM) Programme

1. Complete this form if you are unable to visit your SAMHS medical practitioner to register your chronic condition(s) for the Disease Risk Management Programme.
2. Your chronic condition will be registered based on the information provided by yourself in this form. By completing this form, you confirm that all information provided is accurate.
3. Send the completed form to chronicregistration@rfmcf.co.za for processing.

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																								

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

Dependant / Parent / Guardian Signature **Date**

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).

Section B: Treating Doctor information who diagnosed / treats your chronic conditions

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

Section C: Select the Chronic Condition(s) you have been diagnosed with by your treating doctor:

	Condition	Tick Box	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		
14	Dysrhythmias		
15	Epilepsy		
16	Glaucoma		
17	Haemophilia (A + B)		

Section C: Select the Chronic Condition(s) you have been diagnosed with by your treating doctor:

	Condition	Tick Box	Medicines
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).

2. Consent for processing my personal information.

2.1 I give the Fund and the administrator consent to have access to 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.

Signature of Principal Member

Print Name and Surname of Principal Member

Date D D — M M — 2 0 D D