

Acute dialysis request and update

2026

Important notes:

- Please return the signed and completed form, pathology report(s) and any accompanying documentation by email to: renalcare@momentumhealth.co.za.

1: Member and patient details

1.1 Main member details

1.2 Patient details

Dependant code	<input type="text" value=" "/> <input type="text" value=" "/> <input type="text" value=" "/>	Initials	<input type="text" value=" "/> <input type="text" value=" "/> <input type="text" value=" "/>	First name	<input type="text" value=" "/>		
Title	<input type="text" value=" "/> <input type="text" value=" "/>						
Surname	<input type="text" value=" "/>						
ID number	<input type="text" value=" "/>						
Telephone - home	<input type="text" value=" "/> <input type="text" value=" "/> <input type="text" value=" "/> <input type="text" value=" "/>			Telephone - work	<input type="text" value=" "/>		
Cellphone number	<input type="text" value=" "/> <input type="text" value=" "/>						
Postal address	<input type="text" value=" "/>					Postal code	<input type="text" value=" "/> <input type="text" value=" "/> <input type="text" value=" "/>
Email address	<input type="text" value=" "/>						

2: Patient consent

I understand that Momentum Medical Scheme and Momentum Health, 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 Renal Care Management Programme.

I understand that:

- Funding for this benefit is subject to meeting benefit entry criteria requirements as determined by the Scheme.
- 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 Scheme 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 Scheme 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.
- 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.

4: Clinical information (continued)

4.1 Latest U&E results

Please attach latest U&E results that lead to AHD.

Date blood collected:

Urea

D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y

Potassium

Creatinine

eGFR

D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y

Type of dialysate	NAPPI code(s)	Quantity
Duosol		
Accusol		
Other		
1.		
2.		
3.		

Additional information:

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