momentum

Health4Me Chronic benefit application form

Important notes:

• You can register for chronic benefits by calling us on 0860 10 29 03. Alternatively, please submit the completed and signed form via email to health4mechronic@momentum.co.za.

1: Patient's details

Membership number	Option name								
Principal member's full name(s) and surna	ame								
Patient's full name(s) and surname									
Patient's cellphone number									
Patient's address (for delivery of chronic medication)									
	Postal code								
I authorise my medical practitioner to furnish or disclose any facts relating to this application to Momentum Health4Me.									
Name of signatory									
Signature of member If minor, principal member must sign									

2: For completion by the General practitioner

Chronic medication prescribed

New application		Treatment update									
Diagnosis (eg Hypertension)	ICD-10 code (eg J10)	Medication description	Strength (eg 25mg)	Directions (eg 1/Daily)	Date of diagnosis (month and year)			Repeats (eg 6/12)			
					M	М	Y	Y	Y	Y	
					M	М	Y	Y	Y	Y	
					M	M	Y	Y	Y	Y	
					M	М	Y	Y	Y	Y	

*Please ensure that the ICD-10 codes are completed. We cannot process this application if the codes have not been completed.

List the patient's allergies or other existing medical conditions that the patient may currently be suffering from or medication that he/she is taking:

Supporting clinical information

1. Relevant history - personal (past)

2. Relevant history - family

3. Details of lifestyle and dietary programmes

2: For completion by the General practitioner (continued)

Supporting clinical information (continued)

4. Details of non-medication modalities to manage this patient

Clinical assessment					
Weight	kg	Height c	m BMI Wais	t circumference	cm
Smoking status	Never				
	Ex	Started M M Y Y Y	Stopped M	1 M Y Y Y A	ve/day
	Present	Started M M Y Y Y	Average per day <	3 3 - 10	> 10
Blood pressure reading	Initial			Date D D M M	YYYY
	Present			Date D D M M	YYYY
3: General practition	er's information				
Doctor's name(s) and surname					
Practice number			Fax		
Contact number					
Email address					
Postal address					
				Postal code	
I certify that the specific diagnosi	s indicated above relates	to the medication that I have	e prescribed.		
Signature of General Practi	tioner		D	ate D D M M Y	YYY

Momentum 268 West Avenue Centurion 0157 PO Box 7400 Centurion 0046 South Africa Call Centre 0860 10 29 03 health4me@momentum.co.za momentum.co.za Momentum Health, registration number 1969/016884/07, a Juristic Representative on the Momentum HealthCare Distribution Limited FSP license 27728 and the product is underwritten by Momentum Metropolitan Life Limited, registration number 1904/002186/06, an authorised insurer and financial services provider number 6406. The product terms and conditions apply.