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 surname

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

Date D D M M Y Y Y Y

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 M Y Y Y Y	
					M M Y Y Y Y	
					M M Y Y Y Y	
					M M 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 ___ cm BMI ___ Waist circumference ___ cm

Smoking status

Never

Ex Started M M Y Y Y Y Stopped M M Y Y Y Y Ave/day

Present Started M M Y Y Y Y Average per day < 3 3 - 10 > 10

Blood pressure reading

Initial Date D D M M Y Y Y Y

Present Date D D M M Y Y Y Y

3: General practitioner's information

Doctor's name(s) and surname

Practice number Fax

Contact number

Email address

Postal address

Postal code

I certify that the specific diagnosis indicated above relates to the medication that I have prescribed.

Signature of General Practitioner **Date** D D M M Y Y Y Y