



CHRONIC MEDICATION BENEFIT RENEWAL FORM

A. IMPORTANT INFORMATION

1. One application must be completed per beneficiary applying for chronic medication.
2. Allow **5 working** days for the processing of your application.
3. The original prescription must be given to the provider who dispenses your medication.
4. It is essential that you submit all required information correctly and timeously as incomplete forms will not be processed.
5. Approval of chronic medication is subject to the rules of the Scheme and PROVIDENCE Chronic Protocols
6. You may contact the Pharmacy Benefit Management (PBM) Team at **(041) 395 4482** or email **pbm@providence.co.za**
7. Send completed forms via fax **086 680 8855**, mail **PO Box 1672, Port Elizabeth, 6000** or e-mail **pbm@providence.co.za**

B. MEMBER DETAILS

Scheme	<input type="text"/>	Option	<input type="text"/>
Membership Number	<input type="text"/>		
Surname	<input type="text"/>	First Names	<input type="text"/>
Title	<input type="text"/>	Date of Birth	<input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> M <input type="text"/> M <input type="text"/> D <input type="text"/> D
Telephone number (Home)	<input type="text"/>	(Work)	<input type="text"/>
Fax number (Confidential)	<input type="text"/>	Cellular	<input type="text"/>
Email address (Confidential)	<input type="text"/>		
Postal Address	<input type="text"/>		
	<input type="text"/>		
	<input type="text"/>		
	Code <input type="text"/>		

C. PATIENT DETAILS (Beneficiary who requires Chronic Medication)

Surname	<input type="text"/>	First Names	<input type="text"/>
Title	<input type="text"/>	Date of Birth	<input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> M <input type="text"/> M <input type="text"/> D <input type="text"/> D
Telephone number (Home)	<input type="text"/>	(Work)	<input type="text"/>
Fax number (Confidential)	<input type="text"/>	Cellular	<input type="text"/>
Email address (Confidential)	<input type="text"/>		
The outcome of this application must be communicated to me via my email address: Yes <input type="checkbox"/> No <input type="checkbox"/> OR fax number Yes <input type="checkbox"/> No <input type="checkbox"/>			

D. PATIENT DECLARATION

By signing below, I hereby give permission for, acknowledge and/or agree to the following:

- My (or my minor dependant's) doctor may provide clinical information regarding my/minor's condition to the PBM Team;
 - Any information concerning this application will remain confidential at all times;
 - It may be a pre-condition to the approval of the Chronic Medication Benefit that I register and comply with the requirements of a Disease Management Programme and that non-compliance may lead to the withdrawal of this benefit;
 - My (or my minor dependant's) doctor retains the responsibility for my (or my minor dependant's) condition, based on the understanding that I (or my dependant) also has a responsibility towards my (or my minor dependant's) own health concerns, irrespective of the outcome of this application.
 - This funding authorisation is at all times subject to the Scheme rules even if a member's circumstances change after the authorisation is provided.
- This authorisation is not a guarantee of payment. This funding authorisation is based on the most appropriate clinical criteria in terms of the Scheme rules and protocols. All treatment decisions remain the responsibility of the beneficiary's health care provider irrespective of the funding decision made in terms of the Scheme rules, clinical criteria and protocols. PROVIDENCE shall not accept responsibility for any act, errors or omissions, loss, damage or or consequences of individual responses to the treatment authorised or not authorised for funding by the Scheme.

Patient Signature (or member if patient is a minor) _____ Date Y Y Y Y M M D D

E. PATIENT HEALTH INFORMATION (to be completed by doctor)

Weight	<input type="text"/>	kg	Height	<input type="text"/>	m	Hip/Waist ratio	<input type="text"/>	Smoker?	<input type="text"/> Y <input type="text"/> N	Ave per day	<input type="text"/>	
Exercise: Frequency	<input type="text"/>		X per week			Intensity (Please tick)	Low	<input type="checkbox"/>	Medium	<input type="checkbox"/>	High	<input type="checkbox"/>
Current blood pressure	<input type="text"/>		mmHg			Fasting Blood Glucose (If available)	<input type="text"/>					mmol/L

