Momentum Health Ingwe and Access Members

Health4Me Members

momentum

Chronic Benefit application

Important note:
Chronic benefits may be registered telephonically by contacting **0860 11 78 59** for Momentum Heath Ingwe and Access members, or **0860 10 29 03** for Momentum Health4Me members. Alternatively, please fax the completed and signed form to **031 580 0471** for processing.

Section 1: Patient's Details

Membership number

Option name

Principal member's full name

Patient's full name

I authorise my Medical Practitioner to furnish or disclose to Momentum Health any facts relating to this application.

Name of signatory

Signature of member
If minor, principal member must sign

Date D D - M M - **2 0** Y Y

Section 2: For completion by the General Practitioner

Chronic medication prescribed

Diagnosis (e.g. Hypertension)	ICD10 Code (e.g. J10)	Medication description	Strength (e.g. 25mg)	Directions (e.g. 1/Daily)	Date of diagnosis (month and year)	Repeats (e.g. 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 codes are completed. Failure to provide the codes will render this application null and void.

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 - past personal

2. Relevant history - family

3. Details of lifestyle and dietary programmes

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

Section 2: For completion by the General Practitioner (continued)

Clinical assessment

Weight | Height | BMI

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 — Ave/day <3 | 3 - 10 | >3 /day

Blood pressure reading

Initial — Date D D - M M - Y Y Y Y

Present — Date D D - M M - Y Y Y Y

Section 3: General Practitioner's Information

Doctor's name

Practice number — Fax

Telephone number — Cellphone number

Email

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 - 2 0 Y Y