

2. PATIENT CONSENT (CONTINUED)

Consent for processing my personal information

1. I hereby acknowledge that BP Medical Aid Society has appointed Momentum Health (Pty) Ltd as the administrator of the programme and that any prescribed medical treatment shall be the sole responsibility of my medical practitioner. I understand that the information provided on this form shall be treated as confidential and will not be used or disclosed except for the purpose for which it has been obtained.
2. I hereby give my consent to the Society, Momentum Health and its employees to obtain my, or any of my dependants', special personal information (including general, personal, medical or clinical), whether it relates to the past or future (e.g. health and biometric) from any of my healthcare providers (e.g. pharmacist, pathologist, radiologist, treating doctor and/specialist) to assess my medical risk, enrol me on the programme and to use such information to my benefit and to undertake managed care interventions related to my chronic condition(s).
3. I understand that this information will be used for the purposes of applying for and assessing my funding request for chronic benefits.
4. I give permission for my healthcare provider to provide the Society and the administrator with my diagnosis and other relevant clinical information required to review and process my application.
5. I consent to the Society and the administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical) to my healthcare provider, to administer the chronic benefits.
6. Whilst Momentum Health undertakes to take all reasonable precautions to uphold the confidentiality of information disclosed to it, I am aware that the Society and my healthcare provider (where necessary) shall also gain access to the same information. I shall therefore not hold Momentum Health and its employees or the Society and its trustees, liable for any claims by me or my dependants arising from any unauthorised disclosure of my special personal information to other parties.
7. I understand and agree that special personal information relevant to my current state of health may be disclosed to third parties for the purpose of scientific, epidemiological and/or financial analysis without disclosure of my identity.

I hereby certify that the information provided in this application is true and correct.

Member/patient signature
(or signature of parent/
guardian if patient is under
the age of 18)

Date

DD/MM/YYYY

3. MEDICAL PRACTITIONERS' INFORMATION

DIALYSIS FACILITY

Practice number

Contact number

Email address

TREATING NEPHROLOGIST

Full name and surname

Practice number

Contact number

Email address

Approved authorisation to be sent to:

Full name and surname

Designation

Contact number

Email address

Membership number

Doctor's practice number

4. CLINICAL INFORMATION

ICD-10 code(s) N17.9 N18.9

Type of dialysis AHD CVVHD CRRT SLED

Tariff code for dialysis 75145 75150 75151 75152 75154 75156 75999

Type of authorisation New Update

Date treatment started

Latest U&E results

Please attach latest U&E results that lead to AHD

Date blood collected

Urea	DD/MM/YYYY
Creatinine	DD/MM/YYYY
Potassium	DD/MM/YYYY
eGFR	DD/MM/YYYY

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

Additional information:

Membership number

Doctor's practice number

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11/2024

RENAL CARE MANAGEMENT PROGRAMME

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