Parc du Cap, 7 Mispel Road, Bellville 7530
PO Box 5324 Cape Town 8000
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NURSING CARE BENEFITS APPLICATION FORM

PLEASE NOTE: Sub-acute facilities/alternatives to hospitalisation are subject to pre-authorisation.
Please send completed forms to wellbeing@bpmas.co.za or contact the Disease Risk Management team on 0800 001 607 with any queries.

SECTION A: PATIENT DETAILS AND CONSENT

Scheme: Option:

Full Name: Medical Aid Number:

ID/passport Number: Date of Birth:

Tel Number: Cell Number:

Email Address:

PATIENT CONSENT
I understand that the Scheme and its Administrators will maintain the confidentiality of my personal information and comply with the Protection of Personal Information Act 4 of 2013 (POPIA) and all existing data protection legislation, when collecting, processing and storing my personal information for the purposes of registration for nursing care benefits.

I understand that:

- Funding for this benefit is subject to meeting benefit entry criteria requirements as determined by the Scheme.
- The benefit provides cover for therapy scientifically proven for my condition, which means that not all medication for the condition will automatically be covered.
- By registering for the benefit, I agree that my condition may be subject to disease management interventions and periodic review and that this may include access to my medical records.
- Funding will only be effective once the Scheme receives an application form that is completed in full.
- Payment to the healthcare professional for the completion of this form, on submission of a claim, will be subject to the Scheme rules and where the member is a valid and active member at the service date of the claim.
- I agree to my information being used to develop registries. This means that you give permission for us to collect and record information about your condition and treatment. This data will be analysed, evaluated and used to measure clinical outcomes and to make informed funding decisions.
- To ensure that we pay your claims from the correct benefit, any claims from your healthcare providers must include the relevant ICD-10 diagnosis code(s). Please ask your doctor to also include the relevant ICD-10 diagnosis code(s) on the referral form for any pathology and/or radiology tests. This will enable the pathologists and radiologists to also include the relevant ICD-10 diagnosis code(s) on the claims they submit, thus further ensuring that we pay your claims from the correct benefit.

CONSENT FOR PROCESSING MY PERSONAL INFORMATION

1. I hereby acknowledge 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 Scheme and its Administrators 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/or specialist) to assess my medical risk, enroll 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 Scheme and its Administrators with my diagnosis and other relevant clinical information required to review and process my application.
5. I consent to the Scheme and its Administrators 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 the Scheme and its Administrators undertake to take all reasonable precautions to uphold the confidentiality of information disclosed to them, I am aware that the Scheme and my healthcare provider (where necessary) shall also gain access to the same information. I shall therefore not hold the Scheme and its Administrators 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.

Patient signature: Date:
(or signature of parent/guardian if patient is under the age of 18)

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SECTION B: MEDICAL PRACTITIONERS' INFORMATION

Healthcare Provider Details:

Surname: Initials: Practice No.: Tel:

Speciality: Email:

General Practitioner Details:

Surname: Initials: Practice No.: Tel:

Email:

Nursing Agency Details:

Agency Name: Practice No.: Tel:

Email:

Registered Nurse Details:

Name & Surname: Practice No.: Tel:

Email:

SECTION C: CLINICAL EXAMINATION

TO BE COMPLETED BY A REGISTERED NURSE OR HEALTHCARE PROVIDER

Period for which nursing service is required: From: To:

DETAILS OF DIAGNOSIS

Diagnosis	ICD-10 code(s)	Tariff code(s)

GENERAL CARE REQUIREMENTS

Number of hours of care required per day:

Registered nurse hours Assistant nurse hours

Staff nurse hours Care worker hours

Please define the role of each of these nurses, as they relate to the number of hours of care required:

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SECTION C: CLINICAL EXAMINATION (continued)

PERSONAL CARE STATUS

Feeding:	Independent	Minimal assistance	Must be fed	
Toilet use:	Independent	Minimal assistance	Bladder incontinence	Bowel incontinence
Bathing:	Supervision	Must be bathed	Assistance in/out of the bath	
Dressing and grooming:	Independent	Needs assistance	Supervision only	

General comments:

MENTAL HEALTH STATUS

Need for restraint:	Frequently	Occasionally	Always	Never
Wandering:	Frequently	Occasionally	Always	Never
Behaviour – disorientated:	Frequently	Occasionally	Always	Never
Behaviour – impaired judgement:	Frequently	Occasionally	Always	Never

General comments:

AMBULATION STATUS

Ambulation:	Independent	Independent with device	Aid of one person
	Aid of two people	Unable (bedridden)	
Transferring and positioning:	Independent	Independent with device	Aid of one person
	Aid of two people	Unable	

General comments:

SENSORY STATUS

Vision:	Normal	Partial Impairment	Unable
Hearing:	Normal	Partial Impairment	Unable
Communication:	Normal speech	Speech impairment	Inappropriate content
	Makes needs known with difficulty		Unable to speak

General comments:

OTHER

Pain management:	None required	Some management	Difficult to manage	
Perceptual motor function:	Normal	Partial impairment	Unable	
Compliance with treatment regime:	None	Occasionally	Frequently	Always
Family/social support:	None	Occasionally	Frequently	Always

General comments:

Does the patient have a chronic medication authorisation? Yes No

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SECTION D: MEDICATION AND TREATMENT

TO BE COMPLETED BY A REGISTERED NURSE OR HEALTHCARE PROVIDER

MEDICATION

Name of medication	Frequency (how often is this medication taken?)	Dosage

TREATMENT AND THERAPIES

Treatment	Frequency
Inhalation treatment	
Suctioning	
Tracheostomy care	
Vital signs	
Indwelling catheter	
Intravenous therapy	
Stoma care	
Tube feeding	
Intake and output	
Wound care (please provide details)	
Other treatment recommended (not mentioned above)	

Comments:

SECTION E: ADDITIONAL NURSING CARE NEEDS

TO BE COMPLETED BY A REGISTERED NURSE OR HEALTHCARE PROVIDER

Please specify if there are any additional nursing care needs required that haven't already been covered by the sections above:

Referring doctor's signature: **Date:**