Universal Healthcare Provider Network, a division of Universal Care
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CHRONIC MEDICINE APPLICATION FORM

MEMBER'S DETAILS: TO BE COMPLETED BY APPLICANT. PLEASE PRINT USING BLOCK LETTERS

Member/Employee surname: | Initials: | ID no./Passport no:

First Name: | Membership no.:

Medical Scheme:

AECI Medical Scheme Value Option ☐	Umvuzo Standard Option ☐	WorkerPlan truCARE Option ☐
CompCare Wellness NetworX Option ☐	Umvuzo Ultra Affordable Option ☐	WorkerPlan truHEALTH Option ☐
CompCare Wellness NetworX Efficiency Discount option ☐	Universal Health & Accident Plan Essential ☐	WorkerPlan truWELLNESS Option ☐
Massmart Network Option ☐	Universal Health & Accident Plan Essential Advance ☐	Witbank Coalfields Medical Aid Scheme Ntsika Option ☐
Massmart Essential Option ☐	Universal Health & Accident Plan Standard ☐	Old Mutual Staff Fund Network Option ☐
Tiger Brands Medical Scheme Mzansi Option ☐	Universal Health & Accident Plan Standard Advance ☐	Old Mutual Staff Fund Network *SELECT* Option ☐
Transmed Medical Scheme State Plus Network Option ☐	Universal Health & Accident Plan Comprehensive ☐	
Umvuzo Activator Option ☐	Universal Health & Accident Plan Comprehensive Advance ☐	

PATIENT'S DETAILS: TO BE COMPLETED BY APPLICANT. PLEASE PRINT USING BLOCK LETTERS

Patient's surname: | ID no./ Passport no:

Patient's name: | Age: | Dependant code:

Physical address:

Postal code:

Postal address:

Postal code:

Telephone no.: (H) | Fax no.:

(W) | E-mail address:

(Cell)

DOCTORS DETAILS: TO BE COMPLETED BY APPLICANT. PLEASE PRINT USING BLOCK LETTERS

Doctor's name: | Practice no.:

Telephone no.: | Fax no.:

E-mail address:

PATIENT'S MEDICAL HISTORY: TO BE COMPLETED BY TREATING DOCTOR. PLEASE PRINT USING BLOCK LETTERS. COMPLETE WHICHEVER IS APPLICABLE TO THE PATIENT'S CHRONIC CONDITION.

Gender: M F | Weight: | Height: | BMI: | Smoker: Y N

Waist circumference: | Latest blood pressure (sitting, having rested for 5 min): / mmHg

Blood glucose results: Random | Fasting | Most recent HbA1c result:

Lipogram Results: Total cholesterol | HDL | LDL | Triglyceride

Chronic renal disease: Creatinine clearance | Thyroid: TSH

COPD: Lung function result

HIV: CD4 cell count: | Viral load:

Please indicate if the patient has a history of the following:

Ischaemic heart disease: | Familial hyperlipidaemia

TIA/Stroke: | Peripheral vascular disease:

First degree relative with premature heart disease; (MI in Female <65 years, Male < 55 years)

Universal Healthcare Provider Network requires a copy of blood results (Initial and Latest) where applicable for prompt assessment of the chronic medication application.

CHRONIC MEDICATION: TO BE COMPLETED BY TREATING DOCTOR. PLEASE PRINT USING BLOCK LETTERS

New application ☐ Update ☐ Change in treatment ☐

Please prescribe medicine according to the Universal Provider Network Chronic Formulary.

Diagnosis / Chronic Conditions/ ICD10 code	Medicine and Strength	Dosage	Number of Repeats

PATIENT CONSENT

- I understand that my personal and clinical information will be kept confidential
- I give permission for my doctor to state the diagnosis of my condition
- I confirm that the information contained in the application form is correct

Patient's signature

D D M M Y Y Y Y

DATE

DOCTOR DECLARATION

- I have verified this application against the Universal Chronic Formulary and the Chronic Condition list.
- I hereby declare that the information provided is true and correct.

Doctor's signature

D D M M Y Y Y Y

DATE

Once completed please fax APPLICATION and DOCUMENTS to 086 210 8743 or e-mail to chronicmedicine@universal.co.za