VITREORETINAL DISORDERS APPLICATION FORM

Please attach the relevant Optical Coherence Tomography (OCT) results indicating retinal thickness (initial/most recent).

1. TREATMENT PROTOCOL

1ST LINE TREATMENT	2ND LINE TREATMENT
▪ Avastin/Vitreal S ▪ 3 Injections per treatment cycle	▪ Lucentis/Eylea/Vsiqq/Vabysmo/Ozurdex ▪ Only considered if first line treatment was tried and failed ▪ Lucentis/Eylea/Vsiqq/Vabysmo/Ozurdex – will fund 3 injections per treatment cycle as per registered dose.

Please note:

- **Bilateral approvals will only allow for one consultation for both eyes**
- No treatment will be considered on a continuous basis

2. PARTICULARS OF THE PATIENT

Surname

First name

Membership number

Date of birth D D M M Y Y Y Y

Gender M F

Dependant code

4. MEDICAL QUESTIONNAIRE

Please answer the following questions by indicating with an 'X' in the appropriate column:

4.1. Treatment History		
4.1.1. Has the patient previously received treatment for any vitreoretinal disorders?	Yes	No
4.1.2. If, yes, (a) please specify which medicine		
(b) for which eye(s)	Left	Right / Both
4.1.3. Please specify the previous treatment date(s).	D D M M Y Y Y Y D D M M Y Y Y Y D D M M Y Y Y Y	

Please answer the following questions by indicating with an 'X' in the appropriate column:

4.2. New treatment request

4.2.1. Please provide the ICD-10 code										
4.2.2. What medicine is required?										
4.2.3. Please specify the affected eye(s) where the new treatment is needed.								Left	Right	Both
4.2.4. Please provide the relevant date(s). When will the requested treatment, as per this application form, be performed?	Treatment 1	D	D	M	M	Y	Y	Y	Y	
	Treatment 2	D	D	M	M	Y	Y	Y	Y	
	Treatment 3	D	D	M	M	Y	Y	Y	Y	
4.2.5. Will the treatment be performed at the doctor's practice or in-hospital?								Doctor's practice	In-hospital	

4.2.6. If your procedure is taking place in-hospital, please provide a motivation.

4.2.7. Please provide any additional tariff codes for consideration, with a quantity and motivation.

	TARRIF CODE	QUANTITY	MOTIVATION
1.			
2.			
3.			
4.			
5.			

5. DECLARATION OF ATTENDING DOCTOR

I declare that to the best of my knowledge, all the information is true and accurate, based on the examinations and tests performed on this patient.

Initials | Surname

Full name

Discipline

Practice number

Practice Tel | Fax

E-mail

Doctor's signature

Date D D M M Y Y Y Y

6. CONSENT PROVISIONS BY APPLICANT

1. I hereby expressly make the following acknowledgements in respect of Bestmed's processing of my Personal Information and/or Special Personal Information and/or that of my dependants/child(ren)/spouse(s) ("collectively referred to as "Personal Information"), as defined in terms of the Protection of Personal Information Act, 4 of 2013 (POPIA):
   - 1.1 That I have read and understood the provisions of Bestmed's Data Protection and Privacy Policy, thereby fully appreciating the manner in which Bestmed may process my Personal Information and for which purpose(s) Bestmed may process such Personal Information.
   - 1.2 That through submitting this application, I may be providing Bestmed with the Personal Information of my spouse(s), children and/or other dependant third parties.
   - 1.3 That by engaging with Bestmed through any physical and/or electronic means, Bestmed will in effect be processing the Personal Information provided by me from time to time.
   - 1.4 That Bestmed may from time to time, depending on the circumstances, collect my Personal Information from another source other than myself.
   - 1.5 That I fully appreciate that Bestmed places a high premium on my privacy and/or that of my dependants, spouse(s) and/or children.
   - 1.6 That I have read and understood the undertakings made by Bestmed in its Data Protection and Privacy Policy to the effect that it will ensure that any and all of my Personal Information and/or that of my dependants/child(ren)/spouse(s) shall be processed with a reasonable standard of care as may be expected from Bestmed.
   - 1.7 That I fully appreciate that Bestmed will only process my Personal Information and/or that of my dependants/child(ren)/spouse(s) in a manner consistent with the provisions of its Data Protection and Privacy Policy, as well as for the purpose(s) set forth therein.
   - 1.8 That, in accordance with the provisions of Section 18 of POPIA, I have been provided with adequate notification of the processing of my Personal Information by Bestmed, the scope and purpose(s) for such processing, as well as my rights to object to such processing should I elect to do so.
   - 1.9 That I acknowledge that the processing of my Personal Information is a mandatory requirement for the existence of a valid medical aid.

2. In light of the above acknowledgements, and in accordance with the requirements set forth in Section 11 of POPIA, I hereby provide my specific and informed consent to Bestmed for the processing of my Personal Information and/or that of my dependants/child(ren)/spouse(s), for any purpose(s) legitimately connected or related to my application for membership, which purpose(s) may include, but not be limited to the following:
   - 2.1 To provide or manage any information, products and/or services requested by me pursuant to my application for membership.
   - 2.2 To establish my needs, requirements and preferences in relation to the products and/or services provided by the Bestmed.
   - 2.3 To facilitate the delivery of products and/or services to me as a member of Bestmed.
   - 2.4 To administer my claims and premiums.
   - 2.5 To activate my medical aid and/or prescribed benefits.
   - 2.6 To allocate a unique identifier to me for the purpose of securely storing, retaining, and recalling my Personal Information from time to time, including after my membership is terminated.
   - 2.7 For general administration purposes pertaining to my membership.
   - 2.8 For legal and/or contractual purposes and to enable Bestmed to comply with its contractual obligations towards me.
   - 2.9 To transact with suppliers and business partners, including healthcare service providers, managed facilities, network hospitals, pharmacies and relevant regulatory authorities to facilitate the delivery of products and/or services to me.
   - 2.10 To provide me with health and wellness information throughout the subsistence of my membership.
   - 2.11 To transact with third parties and transfer my Personal Information to such third parties for the purpose of enabling Bestmed to fulfil its contractual obligations towards me.
   - 2.12 To analyse my Personal Information collected for research and statistical purposes.
   - 2.13 To transfer my Personal Information across the borders of South Africa to other jurisdictions should it be required in the legitimate pursuit of Bestmed's business requirements.
   - 2.14 To carry out analysis and profiling of my membership profile.

3. In as far as I provide Bestmed with the Personal Information of any third party, including my spouse(s), children or other dependants, I hereby warrant that I have acquired the consent of such third party to do so and in the event of that individual being a child, I do so in my capacity as a "competent person" in respect of such Personal Information, as contemplated in terms of the provisions of POPIA.

   Accordingly, I hereby indemnify and hold Bestmed harmless against any claims of whatever nature that may arise as a result of the processing of any Personal Information as provided by myself, for purposes of my membership with Bestmed.

4. Bestmed may identify other products and services which might be of interest to me, as well as to inform me of such products and/or services.

Yes	No

Signature of applicant