Administered by momentum health

Application form
Acute dialysis request and update

Once completed and signed, please submit this form along with the pathology reports and any other accompanying documentation by email to renalcare@wooltruhealthcarefund.co.za.

PLEASE COMPLETE ALL SECTIONS IN BLOCK LETTERS

1. MEMBER AND PATIENT INFORMATION

Main member details

Membership number

Benefit option ☐ Network Option ☐ Saver Option ☐ Saver Choice Option ☐ Comprehensive Option

Title | Initials | ID number

Full name and surname

Email address

Patient details

Dependant code

Title | Initials | ID number

Full name and surname

Contact number | Alternative contact number

Kindly indicate your preferred day and time for contact (Monday to Friday between 8:00 and 16:00)

Physical address

Postal code

Email address

Patient consent

I understand that Wooltru Healthcare Fund and Momentum Health (Pty) Ltd, the Administrator, 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 on the Renal Care Management Programme. It is mandatory to provide contact details for all dependants aged 18 and older. The Fund will use these details to communicate directly with the patient or with you, as appropriate.

I understand that:

- Funding for this benefit is subject to meeting benefit entry criteria requirements, as determined by the Fund.
- The benefit provides cover for therapy scientifically proven for my condition, which means that not all medication for the medical 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 Fund 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 Fund rules and where the beneficiary 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.

1. MEMBER AND PATIENT INFORMATION (CONTINUED)

Patient consent (continued)

- 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 Wooltru Healthcare Fund has appointed Momentum Health (Pty) Ltd as the Administrator of this managed care programme and that any prescribed medical treatment shall be the sole responsibility of my attending medical practitioner/ treating doctor. 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 Fund, Momentum Health (Pty) Ltd 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/or 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 Fund and the Administrator with my diagnosis and other relevant clinical information required to review and process my application.
5. I consent to the Fund 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 (Pty) Ltd undertakes to take all reasonable precautions to uphold the confidentiality of information disclosed to it, I am aware that the Fund and my healthcare provider (where necessary) shall also gain access to the same information. I shall therefore not hold Momentum Health (Pty) Ltd and its employees or the Fund 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.
8. I have the right to withdraw my consent to have my information accessed and processed, provided that the lawfulness of the processing of my information before my withdrawal will not be affected. Withdrawal of consent would, however, mean that I will no longer have access to funding from the relevant prescribed minimum benefit (PMB).
9. The Fund's **Privacy Policy** is available on our website.

I, the undersigned, hereby declare that I have carefully read this application form, completed the applicable sections in full, and confirm that all the information provided herein is true and correct to the best of my knowledge. The answers that I have provided in this application are completed in full. I understand that if my application is approved, the information on this application will form the basis of such approval. I understand that it is my responsibility to ensure that the details provided in this application are true and complete, even if this application was completed by my financial adviser, healthcare provider or any other third party on my behalf.

Member/Patient signature

- Signature of parent/legal guardian if patient is under the age of 18

- Signature of legal representative, next of kin, appointed curator or power of attorney if the patient is unable to sign due to incapacity or mental and/or physical disability

Date DD/MM/YYYY

2. MEDICAL FACILITY AND PRACTITIONER'S INFORMATION

Dialysis facility

Practice number | Contact number

Name of facility

Email address

Treating nephrologist

Practice number

Full name and surname

Healthcare facility (if applicable) | Contact number

Email address

2. MEDICAL FACILITY AND PRACTITIONER'S INFORMATION (CONTINUED)

Approved authorisation to be sent to:

Full name and surname			
Designation		Contact number	
Email address			

3. 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 DD/MM/YYYY

Latest U&E results

Please attach latest U&E results that led 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:

Declaration by attending medical practitioner/treating doctor

I, the undersigned, hereby confirm that the information herein has been discussed with the patient and/or their parents, legal guardian or other legal representative. As the attending medical practitioner/treating doctor, I acknowledge my legal responsibility for the accuracy of the information in this application and that Momentum Health (Pty) Ltd will rely on this information when recommending my patient's treatment.

I hereby declare that I have carefully read this application form, completed the applicable sections in full, and confirm that all the information provided herein is true and correct to the best of my knowledge.

Signature of attending medical practitioner/treating doctor

Date DD/MM/YYYY

Renal Care Management Programme

Telephone **0802 228 922**
Email renalcare@wooltruhealthcarefund.co.za
Website www.wooltruhealthcarefund.co.za

03/2026