APPLICATION FORM
HOSPITAL PRE-AUTHORISATION

- Complete this form to ensure that when you call for your hospital authorisation number, it will be a quick and easy process.
- Please note that there will be instances where a quote or motivation may be required.
- You will be issued with a hospital authorisation number once you have applied with the below information.

PLEASE USE BLOCK LETTERS FOR ALL SECTIONS

1. MEMBER AND PATIENT INFORMATION

TO BE COMPLETED BY THE APPLICANT

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 numbers		Home		Work			
		Cell phone					
Postal address							
		Postal code					
Email address							

PATIENT CONSENT

I understand that Wooltru Healthcare Fund and Momentum Health (Pty) Limited, 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 obtaining hospital pre-authorisation.

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 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 member is a valid and active member at the service date of the claim.

Membership number | Doctor's practice number

1. MEMBER AND PATIENT INFORMATION (CONTINUED)

TO BE COMPLETED BY THE APPLICANT (CONTINUED)

PATIENT CONSENT (CONTINUED)

- 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 Wooltru Healthcare Fund has appointed Momentum Health (Pty) Limited 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 Fund, Momentum Health (Pty) Limited 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) Limited 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) Limited 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.

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

2. MEDICAL PRACTITIONERS' INFORMATION

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

HOSPITAL DETAILS

Hospital name

Practice number

ADMITTING DOCTOR'S DETAILS

Practice number

Full name and surname

Speciality

Contact number

Email address

Membership number

Doctor's practice number

3. CLINICAL EXAMINATION

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

Date of admission _____ (DD/MM/YYYY)

DETAILS OF DIAGNOSIS

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

CPT-4 procedure code(s)	Description	Tariff code(s)

PLEASE NOTE: The Wooltru Healthcare Fund Tariff (WHFT) is a rate that has been negotiated between the Fund and healthcare providers. The actual costs charged by the healthcare provider may be higher than the WHFT and the outstanding amount must be paid by you. So remember to negotiate a discount with healthcare providers who charge more than the WHFT. Remember this for all healthcare providers (such as anaesthetists, etc.).

If you think your patient is at risk of being HIV positive, or has been diagnosed as a person living with HIV/AIDS, please advise them to register on the HIV **YourLife** Programme on 0860 109 793 (all calls are confidential).

Admitting doctor's signature _____

Date _____
DD/MM/YYYY

Membership number _____

Doctor's practice number _____