Dyspepsia Conservative Care Programme application form 2025 - High risk patients

(To be completed by treating doctor)

Discovery Health Medical Scheme

Who we are

Discovery Health Medical Scheme, registration number 1125, is a not-for-profit organisation registered with the Council for Medical Schemes, and is the medical scheme you are a member of.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Discovery Health Medical Scheme and takes care of the administration of your membership.

Contact us

Tel (members): **0860 99 88 77**, Tel (health partners): **0860 44 55 66**, www.discovery.co.za, PO Box 784262, Sandton, 2146, 1 Discovery Place, Sandton, 2196.

Purpose of the form

This form is to apply for the Dyspepsia Conservative Care Programme for high risk patients, where the treating network specialist is not registered on HealthID.

What you must do

- Fill in the form in black ink and print clearly, or complete the form digitally.
- All relevant sections must be physically signed by the treating doctor and cannot be signed digitally.
- Fill in section 1 to 3 of the application form and sign section 4.
- Only applications signed by the treating doctor will be accepted.
- Please return the completed application form to us by email to clinicalhelp@discovery.co.za.
- The treating doctor and the patient will receive a letter informing them of our decision and what to do next for approved requests.
- You may call us if you would like to lodge a formal dispute or if you wish to appeal a decision.

1. Patient details

Title | Initials

Surname

First name(s) (as per identity document)

ID or passport number | Membership number

Telephone (H) | Telephone (W)

Cellphone

Email

2. Application (healthcare professional to complete)

ICD-10 code and Description of symptoms experienced	Date of diagnosis
	D D M M Y Y Y Y
	D D M M Y Y Y Y
	D D M M Y Y Y Y

Relevant patient history		Additional information	Tick if applicable
Present history	Prolonged use of non-steroidal anti-inflammatory drugs (NSAIDs)		
	Dyspepsia		
	Reflux		
	Excess alcohol		
	Smoking		
	Other		
Past history	Gastric or peptic ulcer disease		
	Hiatus hernia		
	Other		
Other (list details)			

Previous gastrointestinal (GI) endoscopy history	**Yes** (Tick if applicable)	**No** (Tick if applicable)	**If Yes was selected, insert year when the previous scope took place or state unknown**
Gastroscopy			
Colonoscopy			

2.1 High risk patients

Treatment start date D D M M Y Y Y Y

State the high-risk feature or alarming symptoms in the table below

High-risk feature or alarming symptoms

Is there an indication for surveillance endoscopy (Tick if applicable) Yes No

If yes is selected above, state the indications for surveillance in the table below

Indications for surveillance

Is a gastroscopy required? (Tick if applicable) Yes No

3. Healthcare professional's details (healthcare professional to complete)

First name

Surname

BHF practice number Speciality

Telephone

Email

Notes to Healthcare Professional

3.1. Please ensure that the relevant ICD-10 diagnosis code(s) are used when you submit your claims to the Scheme to ensure payment from the correct benefit.

3.2. Please include the ICD-10 diagnosis code(s) when referring your patient to the pathologists and/or radiologists. This will enable the pathologists and radiologists to include this information on their claims and allow us to pay claims correctly.

3.3. We will approve funding for medicine as per a defined list of medicine applicable to this benefit.

3.4. Please submit all the requested supporting documents with this application to prevent delays in the review process.

3.5. Should you make changes to your patient's treatment plan, you need to let us know so that we can update their authorisation/s. You can do this by emailing the new prescription to us. If you or your patient do not let us know about changes to the treatment plan, we may not pay claims from the correct benefit.

Signature of healthcare professional

Date D D M M Y Y Y Y

Please only sign if information is true, complete and correct.