HERITAGE HEALTH
We care about your health

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A. Oncology Motivation Application

	Membership Number
Principal Member Details Below	
Surname	
First Names	
Personal Postal Address	
Tel Code and Number	
Fax Code and Number	
Cell Phone Number	
Email Address	
Date of Birth	D D M M Y Y Y Y
Gender	Male Female
ID/Passport Number	

B. Of member requesting registration for oncology treatment

Full Names of Patient	
Tel Code and Number	
Fax Code and Number	
Cell Phone Number	
Email Address	
Date of Birth	D D M M Y Y Y Y

I AUTHROISE THE MEDICAL AID FUND TO OBTAIN MORE CLINICAL INFORMATION ON MY/OUR BEHALF

....

SIGNATURE PRINCIPAL MEMBER/PATIENT DATE

C. Of Attending Medical Practitioner

Information to be provided by the doctor

Name of Doctor

Name of Practice

Practice Number

Tel Code and Number

Fax Code and Number

Mobile Number

Email Address

D. Patient history

Primary site

ICD code

Histology

Grade

Performance status/ECOG

Receptors

Date	Previous Treatment	Outcomes	Comments

Disease stage T N M

Other – specify

Metastases Lung Bone Liver

Comorbid diseases

Criteria for PMB condition

Description of condition

PMB code

Spread to adjacent organ

Irreversible/Irreparable damage to organ of origin

Evidence of distant metastatic spread

Demonstrated 5 year survival for this cancer is greater than 10%

Treatment intent and review

Effective date *D* D M M Y Y Y Y

Treatment intent

Chemotherapy

Hormone manipulation

Radiotherapy treatment

Other treatments - specify

SAOC level

In/Out patient

Hospital name

Hospital practice number

Motivation for hospitalisation

Additional comments

Treatment review

_____ _____

SIGANTURE OF DOCTOR DATE

Treatment for radiotherapy

Information to be provided by the doctor

Name of Doctor

Practice Number

Provider Name *Technical*

Provider Number *Technical*

Fax Code and Number

Treatment Date D D M M Y Y Y Y

Area of interest

	Codes	Quantity	Professional fee	Technical fee	Total
Planning code 1					
Planning code 2					
Radiation code 1					
Radiation code 2					
Radiation code 3					
Brachy code 1					
Brachy code 2					
Brachy code 3					
	Supporting	Items Costs		Estimated Total	

Treatment for chemotherapy drugs

Information to be provided by the doctor.

Name of Doctor *Professional*

Practice Number *Professional*

Provider Name *Facility*

Provider Number *Drug*

Treatment Date D D M M Y Y Y Y

Height

Weight

Body surface

Infusional fee code

Infusional fee quantity

Infusional fee amount

Non Infusional fee code

Non Infusional fee quantity

Non Infusional fee amount

Number of cycles

Supporting items (estimate)

s estimate

ted cost per cycle

SAOC equivalent codes

TOTAL estimated cost

Treat for chemotherapy drugs

Drug	Nappi code	Route	Quantity	Frequency	Cost per cycle

Treatment for supporting drugs/isotopes/materials/fluids

Drugs/isotopes/ Materials/fluids	Nappi code	Provider	Route	Quantity	Frequency	Cost per cycle

Doctor's support total	
Radiotherapy support total	
Chemotherapy support total	

E. Authorisation details *(office use)*

Date received: ……

Date processed: ……

Approved: ……

Declined and reason: ……

Inform patient: ……

Employee name: …… Signature: …… Date: ……