ENGEN Medical Benefit Fund

Administered by Discovery Health

Contact details
Tel: 0800 001 615 • PO Box 652509, Benmore 2010 • www.engenmed.co.za

Bariatric surgery application form

Who we are

Engen Medical Benefit Fund (referred to as 'the Fund'), registration number 1572, is a not-for-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the administrator') is a separate company and an authorised financial services provider and is responsible for the administration of your membership on behalf of the Fund.

Purpose of this form

This application form is to apply for funding for bariatric surgery. It must be completed by an accredited surgeon from an accredited centre of excellence who will be performing the surgery. The member must complete sections 3, 4 and 6 of this form. The turnaround time on receipt of a completed form is seven working days. We may need an additional three days if we need to send the request to an external advisory panel before we reach a funding decision.

How to complete this form

1. Fill in the form in black ink and print clearly, or complete the form digitally by using Adobe Acrobat Reader.
2. To avoid administration delays, please ensure this application is completed in full.
3. Send the completed and signed form with the required clinical information and patient consent to us via email at **MOTIVATIONS@engenmed.co.za**

1. Referring healthcare professional details (must be a surgeon, physician or endocrinologist)

Specialist's name

Speciality

Specialist BHF number

Specialist HPCSA registration number

Telephone

Fax

Email

Specialist's signature

Date D D M M Y Y Y Y

Name of facility where the procedure will be done

BHF number of the facility where the procedure will be done

2. Details of the surgeon performing the procedure (if it differs from section 1)

Surgeon name

Specialist BHF number

Specialist HPCSA registration number

Telephone

Fax

Email

Surgeon's signature

Date D D M M Y Y Y Y

3. Main member details

Membership number

ID or passport number

Member's name

Member's surname

4. Patient's details

Title | Initials

First names

Surname

ID or passport number | Membership number

Telephone (H) | Telephone (W)

Cellphone

Email

Relationship to main member

5. Clinical history

1. Current weight in kilograms (kg)	
2. Height in centimetres (cm)	
3. Waist circumference in centimetres (cm)	
4. Body Mass Index (BMI)	
5. Blood pressure Systolic/Diastolic	/
6. Body fat %	% (only for patients <150kg)

Co-morbid illnesses

1. Diabetes mellitus	☐
2. Hypertension	☐
3. Dyslipidaemia	☐
5. Coronary artery disease	☐
6. Other (specify)	☐

Please note: Attach script(s) for the treatment of the above co-morbidities

What is the proposed surgical procedure?

Type of bariatric surgery:

- Roux-en-Y ☐
- Biliopancreatic diversion (BPD) ☐
- Gastric sleeve ☐
- Gastric band ☐

Please attach the following to this application form

1. Report from endocrinologist/physician
2. Report from bariatric surgeon
3. Report from clinical psychologist/psychiatrist
4. Copy of blood results (e.g. fasting glucose, lipogram, TSH, ALT/GGT, CRP etc.)
5. Copy of gastroscopy report
6. Report from biokineticist/physiotherapist (where applicable)
7. Sleep apnoea studies reports (where applicable)
8. Dietician report
9. Supporting documentation from an anaesthetist verifying that the patient is medically fit to undergo an anaesthetic procedure

6. Consent to collection of data for outcomes measurement and registry requirements

I, _____ (patient's name in full), hereby give the Fund and the administrator consent for the collection of all medical/clinical information pertaining to my application for _____ (name of medication/procedure/test) for the treatment of _____ (name of condition) as requested either by me or my consulting doctor, _____ (doctor's name in full). In addition, I specifically consent to the Fund and the administrator having access to my clinical records at my doctor's rooms for the purposes of conducting clinical audits. The information will be used for the purposes of measuring clinical outcomes and developing a registry that will allow the Fund to make informed funding decisions. The confidential nature of the information the Fund and the administrator receives will be respected at all times. I understand that approval for funding for this treatment is conditional upon my cooperation with all aspects of this pre-assessment.

Patient's signature _____ Date D D M M Y Y Y Y