

Dyspepsia Conservative Care Programme application form 2026 - High risk patients

(To be completed by treating doctor)

Contact details

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Who we are

LA Health Medical Scheme (referred to as 'the Scheme'), registration number 1145, is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as 'the Administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Scheme.

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 clinicalhelp@lahealthms.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	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First name(s) (as per identity document)	<input type="text"/>		
ID or passport number	<input type="text"/>	Membership number	<input type="text"/>
Telephone (H)	<input type="text"/>	Telephone (W)	<input type="text"/>
Cellphone	<input type="text"/>		
Email	<input type="text"/>		

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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

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	<input type="checkbox"/>	<input type="checkbox"/>	
Colonoscopy	<input type="checkbox"/>	<input type="checkbox"/>	

2.1 High risk patients

Treatment start date

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)

Surname	<input type="text"/>											
First names	<input type="text"/>											
BHF practice number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Speciality	<input type="text"/>	
Telephone	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email	<input type="text"/>											

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	<input type="text"/>
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Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Please only sign if information is true, complete and correct.