Universal Healthcare Provider Network, a division of Universal Care
Universal House, 15 Tambach Road, Sunninghill Park, Sandton 2191
P O Box 1411, Rivonia 2128
Tel: +27 11 208 1100 / www.universal.co.za

UNIVERSAL NETWORK PATHOLOGY REQUEST FORM

Medical Schemes

CompCare Medical Scheme	Umbono Option	
CompCare Medical Scheme	Umbono ED Option	
Massmart Health Plan	Essential Option	
Massmart Health Plan	Network Option	
Consumer Goods Medical Scheme	Base Option	
Transmed Medical Aid Scheme	Link Option	
Foodmed Medical Scheme	Permanent employees, Pensioners, Seasonal Active employees, Seasonal Inactive 1 and 5	

Old Mutual Staff Medical Aid Fund	Network Option	
Old Mutual Staff Medical Aid Fund	Network SELECT Option	

Non-Medical Schemes

Workplace Health Plan	truVALUE	
Workplace Health Plan	truCARE	
Workplace Health Plan	truHEALTH	
Workplace Health Plan	TRUWELLNESS®	
Universal Health & Accident Plan	Essential Plan	
Universal Health & Accident Plan	Essential Advance Plan	
Universal Health & Accident Plan	Standard Plan	
Universal Health & Accident Plan	Standard Advance Plan	

1. PROVIDER DETAILS

Referring practice name: Practice number:

Copy doctor name: Practice number:

Specimen: Fasting: Random: ICD-10 code:

Testing Laboratory:

Collection date: D D M M Y Y Y Y Collection time: :

2. PATIENT DETAILS:

Surname: First name/s: Initials:

Date of birth: D D M M Y Y Y Y Gender: M F Age:

Telephone no.: (H): ( ) (W): ( )

Cellphone number: E-mail address:

Patient/guardian signature:

I consent to any information reflected on this form, including the ICD-10 code/s and any information that may emanate from the usage of this form pertaining to me or my dependents' being disclosed to Universal Healthcare and my Medical Scheme. I accept that Universal Healthcare and my Medical Scheme will be entitled to utilise the aforementioned data for managed care, risk management and research purposes.

3. MAIN MEMBER / PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT DETAILS:

Surname: First name/s: Initials:

ID no./Passport no.: Employer:

Member/Policy no.:

Telephone no.: (H): ( ) (W): ( )

Cellphone number: E-mail address:

Physical address:

Postal code:

Postal address:

Postal code:

KIDNEYS:		
4113	Potassium	
4114	Sodium	
4151	Urea	
4171	Sodium+potassium+chloride +CO2+urea	
4032	S-Creatinine	
4155	Uric Acid	
HAEMATOLOGY:		
3762	Haemoglobin estimation	
3783	Leucocyte differential count	
3785	Leucocytes: Total count	
3755	Full Blood Count	
3797	Platelet count	
IRON STUDIES:		
4528	Ferritin	
4144	Transferrin	
4071	Iron	
GLUCOSE, DIABETES:		
4057	Glucose random	
4057	Glucose fasting	
4049	GTT - 2 specimens	
4052	GTT - Standard	
4053	GTT - Pregnancy	
4064	HbA1c	
TUMOUR MARKER:		
4519	PSA	
LIPID PROFILE:		
4027	Total Cholesterol	
4026	LDL Cholesterol	
4028	HDL Cholesterol	
4147	Triglyceride	
4025	Lipogram	
LIVER AND PANCREAS:		
4130	Aspartate aminotransferase (AST)	
4131	Alanine aminotransferase (ALT)	
4001	Alkaline Phosphatase	
4134	Gamma glutamyl transferase (ggtA)	
4009	Bilirubin: Total	
4010	Bilirubin: Conjugated	
4006	Amylase	

THYROID FUNCTIONS:		
4507	Thyrotropin (TSH)	
4482	Free thyroxine (FT4)	
DRUG MONITORING:		
4493	Therapeutic drug:	
Drug		
INFLAMMATION MARKERS:		
3947	CRP	
3743	ESR	
CARDIAC ENZYMES:		
4152/4153	CK-MB Mass	
4161	Troponin I/T	
PREGNANCY/ANTENATAL:		
4451	Quantitative (HCG)	
3764	Grouping: A B and O antigens	
3765	Grouping: Rh antigen	
3709	Antiglobulin test (Coombs' or trypsinzied red cells)	
3762	Haemoglobin estimation	
3946/3948	Anticardiolipin IgG and IgM	
CYTOLOGY:		
4566	Pap Smear (one slide)	
4559	Pap Smear (liquid Based)	
COAGULATION:		
3805	PI / INR	
3806	PI / INR Dosage	
SEROLOGY:		
4531	Hepatitis A: Per Antigen or Antibody	
4531	Hepatitis B: Per Antigen or Antibody	
3949	Syphilis	
3951	Quantitative Kahn, VDRL or other flocculation	
MALARIA:		
3865	Parasites in blood smear	
3883	Concentration techniques for parasites	
3792	Plasmodium falciparum: Monoclonal immunological identification	
HIV:		
4614	HIV Rapid test	
3932	HIV Qualitative test (ELISA)	
4429	Viral Load	
3816	CD4 Count	
3974	PCR-Newborn baby	

M. TUBERCULOSIS:		
3881	ZN Stain (mycobacterium) TB	
3885	Cytochemical Stain TB	
3916	Radiometric tuberculosis culture	
3974	GeneXpert TB PCR	
4651	Non-radiometric automated blood cultures	
MICROBIOLOGY:		
3867	Sputum	
	Urine	
	Faecal	
	Other	
Microscopy only		
3895/3901/3909	Culture (all Specimen)	
3887/4653	Sensitivity	
3923/3924/3927/4652	Identification	
4352	Occult blood: Monoclonal antibodies	
HISTOLOGY: BIOPSY/LESION:		
Only with code 0307		
INFERTILITY TESTS:		
Requires pre-authorisation		
COVID TEST:		
3979	COVID-19 Test	
3882	Antigen detection with monoclonal antibodies	
3905	Identification of virus or rickettsia	

NB! COVID-19 pathology tests are not covered on the Universal Health & Accident Plan (UHAP).

Basic Pathology for the Universal Health & Accident Plan (UHAP) are subject to the benefit limit.

Pathology tests that are not listed above will not be covered. If any other pathology tests are requested, please advise members upfront so that they understand the possible financial implications.

Should any other pathology tests be requested for the diagnosis or management of a chronic condition, a motivation is required, and pre-authorisation must be obtained on **0860 111 090**.

REQUESTING PROVIDER SIGNATURE

D D M M Y Y Y Y

DATE

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UNIVERSAL NETWORK RADIOLOGY REQUEST FORM

Medical Schemes

CompCare Medical Scheme	Umbono Option	
CompCare Medical Scheme	Umbono ED Option	
Massmart Health Plan	Essential Option	
Massmart Health Plan	Network Option	
Tiger Brands Medical Scheme	Base Option	
Transmed Medical Aid Scheme	Link Option	

Old Mutual Staff Medical Aid Fund	Network Option	
Old Mutual Staff Medical Aid Fund	Network SELECT Option	
Witbank Coalfields Medical Aid	Ntsika Option	

Non-Medical Schemes

Workplace Health Plan	truVALUE	
Workplace Health Plan	truCARE	
Workplace Health Plan	truHEALTH	
Workplace Health Plan	truWELLNESS	
Universal Health & Accident Plan	Essential Plan	
Universal Health & Accident Plan	Essential Advance Plan	
Universal Health & Accident Plan	Standard Plan	
Universal Health & Accident Plan	Standard Advance Plan	

1. PROVIDER DETAILS

Referring practice name:

Practice number:

Appointment date: D D M M Y Y Y Y

ICD-10 code:

2. PATIENT DETAILS:

Surname:

First name/s:

Initials:

Date of birth: D D M M Y Y Y Y

Gender: M F

Age:

Telephone no.: (H): ( )

(W): ( )

Cellphone number:

E-mail address:

Patient/guardian signature:

I consent to any information reflected on this form, including the ICD-10 code/s and any information that may emanate from the usage of this form pertaining to me or my dependents', being disclosed to Universal Healthcare and my Medical Scheme. I accept that Universal Healthcare and my Medical Scheme will be entitled to utilise the aforementioned data for managed care, risk management and research purposes.

3. MAIN MEMBER / PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT DETAILS:

Surname:

First name/s:

Initials:

ID no./Passport no.:

Employer:

Member/Policy no.:

Telephone no.: (H): ( )

(W): ( )

Cellphone number:

E-mail address:

Physical address:

Postal code:

Postal address:

Postal code:

SKULL		
10100	Skull	
CHEST		
30100	Chest, single view	
30110	Chest, two views, PA and lateral	
30150	Ribs	
30155	Chest and ribs	
ABDOMEN		
40100	Abdomen	
40105	Abdomen supine, erect or decubitus	
REPRODUCTIVE SYSTEM		
ULTRASOUND Only in pregnancy: Not available on Workplace Health Plan truCARE & truVALUE option and Universal Health & Accident Plan: Standard & Standard Advance option. Other schemes/plans: TWO investigations per pregnancy. Additional Ultrasound for complicated pregnancy to be motivated.		
43250	Ultrasound of pregnant uterus – 1st Trimester	
43260	Ultrasound of pregnant uterus – 2nd Trimester	
43270	Ultrasound of pregnant uterus – 3rd Trimester – First Visit	
43273	Ultrasound of pregnant uterus – 3rd Trimester – Follow up	
SPINE, PELVIS AND HIPS		
51110	Cervical spine – one or two views	
52100	Thoracic spine – one or two views	
53110	Lumbar spine – one or two views	
55100	Pelvis	
56100	Hip – Left	
56110	Hip – Right	
56120	Pelvis and hips	
UPPER LIMBS – SHOULDER		
61100	Clavicle – Left	
61105	Clavicle – Right	
61110	Scapula – Left	
61115	Scapula – Right	
61120	Acromio – Clavicular joint – Left	
61125	Acromio – Clavicular joint – Right	
61130	Shoulder – Left	
61135	Shoulder – Right	
FOREARM		
64100	Forearm – Left	
64105	Forearm – Right	
65130	Wrist – Left	
65135	Wrist – Right	

FOREARM (CONTINUES)		
65100	Hand – Left	
65105	Hand – Right	
65120	Finger	
65140	Scaphoid – Left	
65145	Scaphoid – Right	
UPPER ARM		
62100	Humerus – Left	
62105	Humerus – Right	
ELBOW		
63100	Elbow – Left	
63105	Elbow – Right	
KNEE		
72100	Knee, one or two views – Left	
72105	Knee, one or two views – Right	
72120	Knee including patella – Left	
72125	Knee including patella – Right	
72145	Patella – Right	
LOWER LIMBS FEMUR		
71100	Femur – Left	
71105	Femur – Right	
LOWER LEG		
73100	Lower leg – Left	
73105	Lower leg – Right	
ANKLE AND FOOT		
74100	Ankle – Left	
74105	Ankle – Right	
74120	Foot – Left	
74125	Foot – Right	
74130	Calcaneus – Left	
74135	Calcaneus – Right	
74145	Toe	
ULTRASOUNDS		
34100	Mammogram including ultrasound	
34101	X -ray mammography unilateral, including ultrasound	
34200	Ultrasound of the breast	
40210	Ultrasound study of the whole abdomen, including pelvis	
41200	Ultrasound study of upper abdomen	
43220	Ultrasound study of the testes	
43200	Ultrasound of the pelvis	

Please note: Radiology codes that are not listed above will not be covered. If other radiology tests are required, please advise members upfront so that they understand possible financial implications.

Basic Radiology for Universal Health & Accident Plan (UHAP) is subject to the benefit limit.

REQUESTING PROVIDER SIGNATURE

D D M M Y Y Y Y

DATE

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UNIVERSAL NETWORK SPECIALIST REFERRAL FORM

1. MEMBER DETAILS:

Surname: | First name/s: | Initials:

Member ID no./ Passport no:

Cellphone number: | Alternative number:

Medical Scheme: | Membership number:

E-mail address:

2. PATIENT DETAILS:

Surname: | First name/s: | Initials:

Date of birth: (D D M M Y Y Y Y) | Cellphone number:

E-mail address: | Alternative number:

3. REFERING GENERAL PRACTITIONER:

Doctor's name: | Practice number:

Treatment date: (D D M M Y Y Y Y) | Primary ICD-10 code: | Secondary ICD-10 code:

Practice contact details:

4. SPECIALIST REFERRED TO:

Doctor's name: | Practice number:

Appointment date: (D D M M Y Y Y Y) | Authorisation number:

5. INDICATE DESIRED INPUT FROM SPECIALIST:

Make a diagnosis: | Perform a procedure: | Suggest a treatment: | Consider an admission:

6. DETAILED REASON FOR REFERRAL:

Height (cm): ☐ Weight (kg): ☐ BMI: ☐ Pregnant: Yes ☐ No ☐ Smoker: Yes ☐ No ☐

Current chronic conditions:
Medical history:
Motivation for referral (including current treatment plan):

6. ATTACH RELEVANT DOCUMENTATION FOR:

X-rays: ☐ Sonars: ☐ Pathology Results: ☐ Scans: ☐

NB	1. Members must contact 011 208 1100 for prior authorisation before visiting the specialist.
	2. Members are to ensure that the referral form from the General Practitioner is handed to the specialist on the day of the visit, along with authorisation number.
	3. The authorisation number must appear on the specialist's account.
	4. Accounts are to be submitted to the Medical Scheme.
	5. No authorisation will be processed without submission of the fully completed Universal Specialist Referral Form.

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Tel: +27 11 208 1100 / 0860 111 900 / Fax: 0862 108 743
Email: chronicmedicine@universal.co.za / www.universal.co.za

UNIVERSAL CHRONIC MEDICINE APPLICATION FORM

Completing the chronic medicine application form: Please print using block letters
1. Member/Employee to complete section 2 and patient consent and signature section 6
2. Treating doctor to complete section1,3 4,5 and doctor declaration and signature section 6
3. Once completed please email the completed application form to: Chronicmedicine@universal.co.za

1. PROVIDER DETAILS

Practice name: Practice number:

Office Tel: ( ) Email:

Physical address:

Postal code:

Postal address:

Postal code:

2. PATIENT DETAILS

Surname: First name/s:

Date of birth: D D M M Y Y Y Y Gender: M F Age:

Telephone no.: (H): ( ) (W): ( )

Cellphone number: E-mail address:

Physical address:

Postal code:

Postal address:

Postal code:

Occupation: Type of employment:

How would you prefer the outcome of the application status to be communicated to you? E-mail: Telephonically:

3. MEDICAL SCHEME DETAILS/OCCUPATIONAL HEALTH PRODUCTS

Medical Scheme: Medical Scheme Option: Workplace Health Plan:

Member/Policy /ID number: Dependent code:

4. PATIENT'S MEDICAL INFORMATION. (PLEASE PROVIDE INFORMATION RELEVANT TO PATIENT'S CHRONIC CONDITION/S)

Height (cm): Weight (kg): Waist circumference (cm): Date: D D M M Y Y Y Y

BMI: Blood pressure:

***Blood glucose:**

Random: Fasting: GTT: *HbA1c: Date: D D M M Y Y Y Y

***Lipogram:**

Total cholesterol: HDL: LDL Triglyceride:

*CD4 Cell Count: *Viral Load:

Microalbuminuria: *Creatinine clearance: Date: D D M M Y Y Y Y

Lung function:

*FEVI: *FEV/FVC:

Ejection Fraction: Hysterectomy: (Y) (N) Pregnant: (Y) (N)

Expected Delivery Date: D D M M Y Y Y Y

Allergies:

Please indicate if the patient has a history of the following:

Ischaemic heart disease/MI: Familial hyperlipidaemia:

TIA/Stroke: Peripheral vascular disease:

First degree relative with premature heart disease (Female < 65 years/ Male <55 Years)

Has patient been investigated for TB: (Y) (N) Has patient been treated for TB: (Y) (N)

5. CHRONIC MEDICINE APPLICATION (BLOCK LETTERS)

Registration of chronic condition only New application and/or new medicine Change in treatment

Please prescribe according to the formulary. Chronic condition list and Formulary available for lookup on www.universal.co.za

Diagnosis / Chronic Conditions/ ICD10 code	Medicine name and strength	Dosage	Number of repeats if different from ongoing

6. PATIENT AND DOCTOR CONSENT

Patient

- I understand that my personal and clinical information will be kept confidential.
- I give permission for my doctor to state the diagnosis of my condition.
- I confirm that the information contained in the application is correct.

Patient's signature

D D M M Y Y Y Y

Date

Doctor

- I have verified this application against the scheme chronic formulary and the chronic condition list.
- I hereby declare that the information provided is true and correct.

Doctor signature

D D M M Y Y Y Y

Date

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P O Box 1411, Rivonia 2128
Tel: +27 11 208 1100 / www.universal.co.za

PATIENT CONSENT FORM (HIV)

TREATING DOCTOR'S DETAILS

Doctor Name: | Practice No.:

Telephone no.: ( ) | Fax no.: ( )

Cell no.: | E-mail address:

PATIENT CONSENT FOR THE RELEASE OF MEDICAL INFORMATION

MEDICAL AID SCHEMES

Medical Schemes

CompCare Medical Scheme	Umbono Option	
CompCare Medical Scheme	NetworX ED Option	
Massmart Health Plan	Essential Option	
Massmart Health Plan	Network Option	
Tiger Brands Medical Scheme	Base Option	
Transmed Medical Aid Scheme	Link Option	

Old Mutual Staff Medical Aid Fund	Network Option	
Old Mutual Staff Medical Aid Fund	Network SELECT Option	
Witbank Coalfields Medical Aid	Ntsika Option	

Occupational Health & Insurance Products

Workplace Health Plan	truCare	
Workplace Health Plan	truValue	
Workplace Health Plan	truHealth	
Workplace Health Plan	truWellness	
Universal Health & Accident Plan	Essential Advance Plan	
Universal Health & Accident Plan	Standard Plan	
Universal Health & Accident Plan	Standard Advance Plan	

MEMBER'S DETAILS

Surname: | Initials: | ID/Passport no:

Membership No:

PATIENT'S DETAILS

Surname: | ID/Passport no:

First Name: | Age: | Dependant Code:

Physical address:

Postal code:

Postal address:

Postal code:

Telephone no.: ( ) | Fax no.: ( )

PATIENT'S CONSENT

I _____ hereby give consent to:

- Allow the Universal Care HIV counsellors to obtain clinical information and records relating to me or my dependants' (child or legal beneficiary) health, treatment and any other aspects of medical care provided,
- Allow any health care worker responsible for the management of my treatment to share my clinical information with the Universal Care HIV counsellors or Case Managers.
- I confirm/understand that:
- Counselling/education on HIV/AIDS has been offered to me in a language that I understand,
- I am able to make an informed decision to voluntarily join the Universal Care HIV programme,
- A Universal Care counsellor will be available for me to consult should I require it,
- The purpose of performing diagnostic pathology tests is to establish my HIV status, to monitor, clinically treat and manage my HIV and that I understand the implications of knowing my HIV status,
- Ongoing testing and monitoring of my condition is required as part of the programme and that the treatment protocol may change based on the outcome of any test,
- Should I not comply with the programme protocols or prescribed treatment that the Medical Scheme, at its sole discretion, may elect to exercise its right to limit my benefits to the statutory prescribed minimum benefits,
- I voluntarily consent to the drawing of blood samples and to the testing of such blood samples in order to establish my HIV status, as well as the subsequent drawing and testing of blood samples to monitor and treat my HIV condition,
- Universal Care is the administrator of the programme and that my selected GP is responsible for the management of my condition, including the prescription of medication. Therefore Universal Care or the Medical Scheme will not be liable for claims by me or my dependants arising from my participation in the programme.
- My clinical information regarding my HIV status will not be shared with my employer without my written consent,
- I may voluntarily withdraw from the programme, but understand the implication thereof,
- That all the information I have provided for the completion of this form is accurate and complete,
- I have been given a copy of this document.

Patient Signature

This consent is in respect of any matter on file with any physician or health care provider. The information obtained will not be divulged to any other individual, institution or organization, except to such persons who are required to receive such information in the ordinary course of their employment at Universal Care or the Medical Scheme's administrator or the Medical Scheme itself. Universal Care and its employees shall not be held liable should my personal information or HIV status be unauthorised and unintentionally disclosed to a third party or revealed to a third party through coding of accounts using ICD10 codes.

Signed at:

Witness Signature

Witness Full Name:

D D M M Y Y Y Y

Date