Contact details
Tel: 0860 101 252 • PO Box 652509, Benmore 2010 • www.retailmedicalscheme.co.za

HIVCare Programme application form

You are completing this application to join the HIVCare Programme and to apply for antiretroviral medicine. Cover for antiretroviral medicine is available on both benefit options, subject to the Scheme rules and the terms and conditions of the HIVCare Programme.

You must use a Premier Plus HIV Network GP to manage your condition to avoid a 20% co-payment on consultations.

Who we are
Retail Medical Scheme (referred to as 'the Scheme'), registration number 1176, 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). Discovery Health (Pty) Ltd administers the Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly
2. You (the patient) must complete Section 1 to 2 of this form and sign section 2.
3. Your doctor must complete Section 3 to 7 if you need medicine.
4. Please remember to send the patient's most recent relevant blood results with this form.
5. Please email this completed and signed form with any support documentation to **HIV_Diseasemanagement@retailmedicalscheme.co.za** or post it to PO Box 536, Rivonia, 2128.
6. You can also contact our call centre on **0860 101 252** if you have any questions.

Consent for processing your personal information
I give the Scheme and the administrator consent to have access to and process all information (including general, personal, medical or clinical information) that is relevant to this application. I understand that this information will be used for the purposes of applying for and assessing my funding request for the HIV benefit. I consent to the Scheme and the administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical information) to my healthcare provider and to relevant third parties, to administer the HIV Benefit as well as undertake managed care interventions related to the chronic condition.

Consent for withdrawal for your Disease Management Benefits
Withdrawing consent for your general, personal, medical or clinical information to be accessed or shared with relevant third parties, means that you will no longer have access to funding from the applicable disease management benefits. Claims which would usually be funded from the disease management benefits will, once consent is withdrawn, be funded from other available benefits according to the rules of your benefit option.Should you wish to continue with the consent withdrawal process, then please email **HIV_Diseasemanagement@retailmedicalscheme.co.za**

1. Patient details

Title | Initials

First name(s)

Surname

Membership number

ID or passport number

Telephone (H) | Telephone (W)

Cellphone

Email

Relationship to main member

May we communicate your confidential information to this

Email address Yes ☐ No ☐

Or SMS Yes ☐ No ☐

Best time to call ☐☐ : ☐☐

Please note: our case managers work between 08:00 and 17:00 Monday to Friday excluding public holidays.

Patient's signature

(If the patient is a minor the main member needs to sign)

Date D D M M Y Y Y Y

2. Main member details

Membership number

ID or passport number

Member's name

Member's surname

3. Clinical data and examination (to be completed by the doctor)

Note: Investigation results are essential for registration. Please provide copies of recent reports (for the last three months).

Date of last test D D M M Y Y Y Y

More pathology investigations will be useful for a full clinical picture. Please provide copies of the following reports:

Full blood count ☐ Liver function test ☐ Urea and creatinine ☐

Is the member pregnant? Yes ☐ No ☐

If Yes, expected date of delivery? D D M M Y Y Y Y

Height ☐☐☐ m) Weight ☐☐ (kg)

4. Other clinical data required (to be completed by the doctor)

Date of diagnosis D D M M Y Y Y Y

4.1 Clinical staging (Centre for Disease Control or World Health Organization)

4.2 Clinical information to substantiate staging in point 1

4.3 Drug history

Medicine	Duration of treatment	Please insert reason or code (detailed below) for discontinuation of previous antiretroviral therapy

Reason or code for discontinuation: Side effects ☐ Cost ☐ Resistance ☐ Other ☐

If other, please provide a brief explanation

Please specify any other medicine that the patient uses on a regular basis

5. Medicine required for HIV and AIDS (to be completed by the doctor)

The HIVCare Programme provides cover for disease-modifying therapy. Medicine used for symptomatic control is not covered.

Diagnosis	Date when condition was first diagnosed	Medicine name, strength and dosage	Number of repeats	How long has the patient used this medicine?		May the patient use a generic medicine?	
				Years	Months	Yes	No
HIV							
Opportunistic infections							

6. Doctor's details (to be completed by doctor)

Name

Telephone

Practice email

Practice number

I confirm that I have received the patient's consent to disclose their HIV status and other medical information in this form to the Scheme and Discovery Health (Pty) Limited.

Doctor's signature

Date D D M M Y Y Y Y

7. Address for delivery of medicine

Contact person

Address

Telephone (H)

Telephone (W)

Cellphone