Request for pre-exposure prophylaxis (PREP)

NETCARE MEDICAL SCHEME
Administered by Discovery Health

Contact details
Tel: 0861 638 633 • PO Box 652509, Benmore, 2010 • www.netcaremedicalscheme.co.za

This application form is to register for pre-exposure prophylaxis and to apply for antiretroviral prophylaxis medicine. Cover for antiretroviral prophylaxis medicine is available subject to the Scheme Rules and the terms and conditions of the benefit.

This form is valid for 2019.

Who we are

Netcare Medical Scheme, registration number 1584, is a non-profit organization, 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), which takes care of the administration of your membership of Netcare Medical Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. Please make sure the form is completed in full and signed by a healthcare professional.
3. Once complete, please email it to **hiv@netcaremedicalscheme.co.za**

1. Patient details

Title | Surname

First name/s

Date of birth (Y Y Y Y M M D D) | ID or passport number | Sex (M F)

Membership number

Telephone (H) | (W)

Cellphone | Fax

Email address

The outcome of this application must be sent to me by ☐ Email ☐ Fax

Please ensure your contact details are always up to date as we rely on this information to keep you updated. You may update your details on www.netcaremedicalscheme.co.za

2. Main member details (Please ONLY complete this section if the patient is a minor)

Title | Surname

First name/s

Date of birth (Y Y Y Y M M D D) | ID or passport number | Sex (M F)

Membership number

Telephone (H) | (W)

Cellphone | Fax

Email address

Patient's signature
(if patient is a minor, main member must sign)

Original hand signature required

Date (Y Y Y Y M M D D)

Patient's name and surname

Membership number

3. Clinical data (to be completed by doctor)

Expected treatment start date: Y Y Y Y M M D D

Expected duration of treatment:

Clinical reason for requesting PREP:

Special investigation results (please provide copies of the reports):

Test done?			If yes, specify results	Test date
Baseline HIV test*	☐ Yes	☐ No		Y Y Y Y M M D D
Serum Creatinine/eGFR	☐ Yes	☐ No		Y Y Y Y M M D D

*We need a negative ELISA result that is less than 1 month old before we can approve the treatment.

4. Medicine (to be completed by doctor)

Medicine	Dosage	Duration of treatment

Please specify any other medicine that the patient uses regularly

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

Name

BHF practice number

Telephone

Fax

Cellphone

Email

I acknowledge that the approval of this treatment is subject to the HIV status of the patient and that I have received the patient's consent to disclose their HIV status and any other related information to Netcare Medical Scheme and Discovery Health (Pty) Ltd.

Signature of doctor Original hand signature required

Date Y Y Y Y M M D D

Netcare Medical Scheme is a registered medical scheme with the Council for Medical Schemes (CMS). The CMS contact details are as follows: email: complaints@medicalschemes.com / Customer Care Centre: 0861 123 267 / website: www.medicalschemes.com

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