

# HIVCare Programme application form



## Contact details

Tel: 0861 638 633 • PO Box 652509, Benmore 2010 • [www.netcaremedicalscheme.co.za](http://www.netcaremedicalscheme.co.za)

This application form is to join the HIVCare Programme and to apply for antiretroviral medicine. Cover for antiretroviral medicine is available on the Netcare Medical Scheme, subject to the Scheme rules and the terms and conditions of the HIVCare Programme.

This form is valid for 2022, the latest version of the application form is available on [www.netcaremedicalscheme.co.za](http://www.netcaremedicalscheme.co.za)

## 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 for Netcare Medical Scheme.

## How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. A note to the treating healthcare professional: Please remember to send the patient's most recent relevant blood results with this form.
3. You (the member) must complete Section 1 to 2 of this form and sign section 2.
4. Your doctor must complete Section 3 to 7 if you need medicine.
5. Please email this completed and signed form with any support documentation to [HIV@netcaremedicalscheme.co.za](mailto:HIV@netcaremedicalscheme.co.za) or fax to **011 539 3151** or post it to **PO Box 536, Rivonia, 2128**.

## 1. Patient details

Title	<input type="text"/>	Surname	<input type="text"/>
First name/s	<input type="text"/>		
Date of birth	<input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> M <input type="text"/> M <input type="text"/> D <input type="text"/> D	ID or passport number	<input type="text"/>
Gender	M <input type="checkbox"/> F <input type="checkbox"/>	Membership number	<input type="text"/>
Telephone (H)	<input type="text"/>	(W)	<input type="text"/>
Cellphone	<input type="text"/>	Fax	<input type="text"/>
Email address	<input type="text"/>		

Outcome of this application must be sent to me by: Email  Post

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](http://www.netcaremedicalscheme.co.za)

## 2. Member information (if patient is a minor)

Title	<input type="text"/>	Surname	<input type="text"/>
First name/s	<input type="text"/>		
Date of birth	<input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> M <input type="text"/> M <input type="text"/> D <input type="text"/> D	ID or passport number	<input type="text"/>
Gender	M <input type="checkbox"/> F <input type="checkbox"/>	Membership number	<input type="text"/>
Telephone (H)	<input type="text"/>	(W)	<input type="text"/>
Cell phone	<input type="text"/>	Fax	<input type="text"/>
Email address	<input type="text"/>		

Main member's signature

Date

(if patient is a minor, main member must sign)

Patient's name and surname

Membership number

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

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

CD4 count  Viral load  Full blood count  Liver function test  Urea and creatinine

Is the patient pregnant? Yes  No

If yes, expected date of delivery

Height  (cm) Weight  (kg)

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

Date of diagnosis

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

  

4.4. Is the patient being treated for one or more of the below conditions (please check the appropriate block):

Diabetes  Epilepsy  Hypercholesterolemia  Depression/psychiatric treatment  Tuberculosis (TB)   
Cancer  Chronic renal failure  Hypertension/Cardiac failure  Other

4.5. If "other", please provide a brief explanation

  

4.6. List the medicine the patient is currently taking for the above condition/s (if applicable)

  

Patient's name and surname

Policy Number

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

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							

We will approve funding for generic medicine where available, unless you have indicated otherwise

## 6. Doctor's details (to be completed by the doctor) - HIV Prep

Name

BHF Practice number  Speciality

Telephone

Cellphone

Email

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

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 Discovery Health Medical Scheme and Discovery Health (Pty) Ltd.

Doctor's signature

Date

Please only sign if information is true, complete and correct.