

Discovery HIVCare Programme application form



Contact us

Tel: 0860 99 88 77, PO Box 784262, Sandton, 2146, www.discovery.co.za

This application form is to join Discovery's HIVCare Programme and to apply for antiretroviral therapy (ART). Cover for antiretroviral therapy is available through the Chronic Illness Benefit on all Discovery Health Plans subject to the scheme rules.

How to complete this application form

A note to the treating healthcare professional.

Please remember to send the patient's most recent relevant blood results with this form.

Send the completed and signed form to us by:

- Fax: **011 539 3151**
- Email: **DCO_HIV_CASEMANAGERS@discovery.co.za**
- Post: PO Box 536, Rivonia, 2128

Please call us on 0860 99 88 77 if you have any questions about your application.

We will approve antiretroviral medicine once the terms and conditions are met and based on our list of medicines.

Antiretroviral medicine not on the list will be paid for up to a monthly Chronic Drug Amount except on KeyCare Plans.

There is some medicine that the Chronic Illness Benefit does not cover. The Scheme will pay for certain multivitamins and vaccines according to the medicine list up to a limit for the year.

What you must do

Please go through these steps:

Step 1: Fill in section 1 to 3 of the application form and sign section 3.

Step 2: Take the form to your doctor to complete section 4 to 8 if you need medicine.

1. Main member details (information about the member)

Title	<input type="text"/>	Surname	<input type="text"/>
First names (as per identity document)	<input type="text"/>		
Discovery Health membership number	<input type="text"/>		
Date of birth	<input type="text"/>	Identity number	<input type="text"/>
Telephone (H)	<input type="text"/>	(W)	<input type="text"/>
Other	<input type="text"/>	Fax	<input type="text"/>
Cellphone	<input type="text"/>		
Email address	<input type="text"/>		

2. 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"/>	Date of birth	<input type="text"/>	Sex	<input type="text"/>
Relationship to main member	<input type="text"/>	Sex	<input type="text"/>	(W)	<input type="text"/>
Telephone (H)	<input type="text"/>	Fax	<input type="text"/>	(W)	<input type="text"/>
Cellphone	<input type="text"/>	Fax	<input type="text"/>	(W)	<input type="text"/>
Email address	<input type="text"/>				

May we communicate your confidential information to this email address Yes No or fax number 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 name and surname

Membership number

3. Legal declaration

I understand that Discovery must access my personal clinical information to make recommendations about my chronic medicine needs and to provide me with the full benefits of the Discovery HIVCare Programme. I authorise any third party, disease management, previous scheme or healthcare professionals for example pathology laboratories, doctors and hospitals in possession of any medical information about my dependants (if minor) or myself to provide Discovery with any information that they may need, with the exception of any information that I stipulate in writing may not be provided to Discovery. I acknowledge that my healthcare professional is responsible for my diagnosis and treatment.

I consent to Discovery disclosing my information to pharmacies and contracted providers of disease management programmes as is necessary to ensure that I receive the full benefits of the Discovery HIVCare Programme. I understand that the pharmacies and providers are bound by obligations of confidentiality.

Patient's signature

Date

(main member to sign if patient is a minor)

4. 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 (m) Weight (kg) BSA (for children)

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

Date of diagnosis

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

2. Clinical information to substantiate staging in point 1

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: A Side effects B Cost C Resistance D Other

If **other**, please provide a brief explanation

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

6. 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

Patient's name and surname

Membership number

7. Address for delivery of medicine

Contact person

Address

Code

Telephone (H) (W)

Cellphone Fax

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

Name

Telephone Fax

Practice email

BHF practice number

Preferred means of communication Email Fax

Doctor's signature Date

Note to doctor: The doctor's fee for completion of this form will be reimbursed on code 0199 provided that the patient is a member of the Scheme at the time of application. Payment of the claim will be made from the member's Medical Savings Account, subject to the member's health plan and availability of funds. Please also note that the pharmacy will need a new script every six months.