

HIVCare Programme Application form



Contact details

Tel: 0860 116 116 • PO Box 652509, Benmore 2010 • www.yourremedi.co.za

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

This form is valid for 2024, the latest version of the application form is available on www.yourremedi.co.za

Who we are

Remedi is the medical scheme, registration number 1430, which 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), which takes care of the administration of your membership for Remedi.

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 6 if you need medicine.
5. Please email this completed and signed form with any support documentation to HIV@yourremedi.co.za or fax it to **011 539 3151** or post it to **PO Box 536, Rivonia, 2128**.
6. You can also contact our call centre on **0860 100 693** if you have any questions.
7. Consent for processing my 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.

8. Consent 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 plan. Should you wish to continue with the consent withdrawal process, then please email HIV@yourremedi.co.za.

1. Patient details

Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First name/s (as per identity document)	<input type="text"/>		
Membership number	<input type="text"/>		
ID or passport number	<input type="text"/>		
Telephone (H)	<input type="text"/>	Telephone (W)	<input type="text"/>
Cell phone	<input type="text"/>	<input type="text"/>	
Email address	<input type="text"/>		
Relationship to main member	<input type="text"/>		

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.yourremedi.co.za.

2. Main member details

Membership number	<input type="text"/>
ID or passport number	<input type="text"/>
Member’s name	<input type="text"/>
Member’s surname	<input type="text"/>

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

Membership 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 generic medicine?	
				Years	Months	Yes	No
HIV							
Opportunistic infections							

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

Name

BHF practice number Telephone

Cellphone Fax

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

Signature of doctor Date

Original hand signature required

Signature of doctor

 **Original hand signature required**
Please only sign if information is true, complete and correct.