HIVCare Programme Application form

REMEDI
Administered by Discovery Health

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 2021, 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 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_Diseasemanagement@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.

1. Patient details

Title | Initials | Surname

First name/s (as per identity document)

Membership number

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

Sex M F

Telephone (H) | (W)

Cell phone | Fax

Email address

How would you prefer to receive this letter? 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.yourremedi.co.za

Patient's name and surname

Membership number

2. Member information (if 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)

Cell phone | Fax

Email address

Main member's signature

Date D D M M Y Y Y Y

(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

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

The outcome of this application must be sent to me by Email ☐ 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 Remedi Medical Aid Scheme and Discovery Health (Pty) Ltd.

Signature of doctor

Date D D M M Y Y Y Y

Original hand signature required

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