

HIVCare Programme application form

Contact details

Tel: 0860 103 933 • PO Box 652509, Benmore 2010 • www.lahealth.co.za

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

If you are on a LA Comprehensive, LA Core, LA Active or LA Focus option, you must use a Premier Plus HIV Network GP to manage your condition to avoid a 20% co-payment on consultations.

If you are on a LA KeyPlus option, you must make use of a LA KeyCare Network GP and a Premier Plus HIV Network GP to avoid a 20% co-payment on consultations. Additionally, if you are on the KeyPlus option Please log on to the LA Health website (www.lahealth.co.za) to confirm a Designated Service Provider pharmacy near you or contact MedXpress.

Please always look at the latest version of the medicine lists available at www.lahealth.co.za

Who we are

LA Health Medical Scheme (referred to as 'the Scheme'), registration number 1145, 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). We take care of the administration of your membership for the Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. 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@discovery.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 103 933** if you have any questions.

1. Patient details

Title	<input type="text"/>	Surname	<input type="text"/>
First name/s	<input type="text"/>		
Date of birth	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	ID or passport number	<input type="text"/>
Sex	M <input type="checkbox"/> F <input type="checkbox"/>	Membership number	<input type="text"/>
Telephone (H)	<input type="text"/> - <input type="text"/>	(W)	<input type="text"/> - <input type="text"/>
Cellphone	<input type="text"/> - <input type="text"/>	Fax	<input type="text"/> - <input type="text"/>
Email address	<input type="text"/>		
The outcome of this application must be sent to me by: Email <input type="checkbox"/> Fax <input type="checkbox"/>			

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

Patient's name and surname	<input type="text"/>
Membership number	<input type="text"/>

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

Title	<input type="text"/>	Surname	<input type="text"/>
First name/s	<input type="text"/>		
Date of birth	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	ID or passport number	<input type="text"/>

LHHPA001

Sex M F Membership number

Telephone (H) - Work -

Cellphone - Fax -

Email address

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

Main member's signature Date

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
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

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	Reason if 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 doctor)

Name

Telephone Fax

Practice email

Practice number

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

I confirm that I have received the patient's consent to disclose their HIV status and other medical information in this form to the Scheme and Discovery Health (Pty) Limited.

Doctor's signature

Date