Request for HIV pre-exposure prophylaxis (PREP) 2024

Discovery Health Medical Scheme

Who we are

Discovery Health Medical Scheme, registration number 1125, is a not-for-profit organisation registered with the Council for Medical Schemes, and is the medical scheme that you are a member of.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Discovery Health Medical Scheme and takes care of the administration of your membership.

Contact us

Tel (members): **0860 99 88 77**, Tel (health partners): **0860 44 55 66**, **www.discovery.co.za**, PO Box 784262, Sandton, 2146, 1 Discovery Place, Sandton, 2196**.**

Purpose of the form

This application form is to apply for pre-exposure prophylaxis (medicine to prevent or reduce the risk of HIV infection for individuals at high risk).

What you must do

- Fill in the form in black ink and print clearly or complete the form digitally. You can view the list of approved digital signature providers on **www.discovery.co.za,** under Medical Aid > Find documents and certificates > Application forms.
- All relevant sections must be signed. The patient must sign and date any changes.
- Please ensure the form is completed in full and signed by a healthcare professional.
- Please return the completed form to us by email to **HIV_Diseasemanagement@discovery.co.za** or post it to PO Box 536, Rivonia, 2128.
- There is overwhelming medical evidence that patients experience improved health outcomes when their primary care is coordinated through a single primary care GP. In line with this best practice, starting 1 January 2024, for members on all health plans except the Executive Plan, you and your dependants need to nominate a primary care GP for the effective management of your chronic conditions. If you are on any health plan except the Executive Plan, when you visit your nominated network GP for the management of your chronic condition, we'll cover the consultation at 100% of the Discovery Health Rate (DHR). If you see a GP who is not your nominated primary care GP, or your nominated GP is not a network GP, you will be responsible for any co-payments. You and your dependants can change your nomination three times every calendar year. Nominate your GP or manage your existing nomination on **www.discovery.co.za** > Medical aid > Nominate a primary Care GP.

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 PREP 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 PREP Benefit as well as undertake managed care interventions related to the benefit. You can view and read our Privacy Statement on **www.discovery.co.za** > Medical aid > **About Discovery Health Medical Scheme**.

1. Patient details

Title | Initials

First name(s)

Surname

Preferred name

Gender M F | Date of birth D D M M Y Y Y Y

ID or passport number | Membership number

Telephone (H) | Telephone (W)

Cellphone

Email

The outcome of this application will be communicated to you by email.

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.discovery.co.za.

Signature of patient | Date D D M M Y Y Y Y

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

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

Title | Initials

First name(s)

Surname

Preferred name

Gender M F | Date of birth D D M M Y Y Y Y

ID or passport number | Membership number

Telephone (H) | Telephone (W)

Cellphone

Email

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.discovery.co.za.

Signature of member | Date D D M M Y Y Y Y

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

3. Clinical data (to be completed by doctor)

Expected treatment start date D D M M Y Y Y Y

Expected duration of treatment

Clinical reason for requesting PREP:

Patient's name

Patient's surname

Membership number

Special investigation results (please provide copies of the reports):

	Test done?	If yes, specify results	Test date
Baseline HIV test*	Yes No		D D M M Y Y Y Y
Serum Creatinine/eGFR	Yes No		D D M M Y Y Y Y

*We require a negative ELISA result from a test completed within one month of the date of submission, before we will approve treatment.

4. Medicine (to be completed by doctor)

Medicine name	Dosage	Duration

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

5. Doctor's details (to be completed by treating doctor)

First name(s)

Surname

BHF practice number

Billing practice number

Group practice number

Speciality

Telephone

Email (preferred email to receive patient progress reports)

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.

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_Diseasemanagement@discovery.co.za**.

Signature of doctor

Date D D M M Y Y Y Y

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