ANGLOVAAL GROUP MEDICAL SCHEME

Administered by Discovery Health

Contact details
Tel: 0860 100 693 • PO Box 652509, Benmore 2010 • www.avgms.co.za

HIVCare Programme application form

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.

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

Who we are

The Anglovaal Group Medical Scheme (referred to as 'the Scheme'), registration number 1571, 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. **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@avgms.co.za** or post it to PO Box 536, Rivonia, 2128.
6. You You can also contact our call centre on **0860 100 693** if you have any questions.

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.

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@avgms.co.za**.

1. Patient details

Title | Initials

First name/s

Surname

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

Race African | Coloured | Indian/Asian | White | Other | Do not want to disclose

This information is required by the Council for Medical Scheme for statistical purposes. You are not compelled to provide this information.

Membership number

ID or passport number

Telephone (H) | Telephone (W)

Cellphone

Email address

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.avgms.co.za

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

Title | Surname

First names (as per identity document)

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

Telephone (H) | Telephone (W)

Cellphone

Email address

Patient's signature | Date (D D M M Y Y Y Y)

(If patient is a minor,main member must sign)

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 (D D M M Y Y Y Y)

Height (cm) | Weight (kg)

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

Date of diagnosis (D D M M Y Y Y Y)

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

4.2 Clinical information to substantiate staging in point 1

4.3 Medicine 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)

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 the doctor)

Name

Telephone

Practice email

Practice number

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 Y Y Y Y M M D D