HIVCare Programme application form

LA Health
Powered by Discovery

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 options, subject to the Scheme rules and the terms and conditions of the HIVCare Programme.

If you are on the 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 the LA KeyPlus option, you must make use of a KeyCare Network GP and a Premier Plus HIV Network GP to avoid a 20% co-payment on consultations. Additionally, if you are on the LA 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, the Scheme's courier pharmacy.

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

For LA KeyPlus members: In 2023, if you are registered for a chronic condition, you will be prompted to nominate a primary care network doctor. This nomination process will not impact your benefits and cover in 2023. We will share communication during the course of 2023 to explain:

- The process to follow to nominate your primary care doctor (GP)
- How to change your nominated GP, if necessary.

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 ____ Surname ____

First name/s ____

Date of birth D D M M Y Y Y Y ID or passport number ____

Sex M ☐ F ☐ Membership number ____

Telephone ____ - ____ Work ____ - ____

Cellphone ____ - ____

Personal email ____

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 ____

Membership number ____

LHHPA001

Please note that this form expires on 31/03/2024. Up to date forms are available on www.lahealth.co.za.

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

Title | | | | Surname

First name/s

Date of birth D D M M Y Y Y Y ID or passport number

Sex M F Membership number

Telephone - Work -

Cellphone -

Personal email

Main member's signature Date D D M M Y Y Y Y

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 Y Y Y Y M M D D

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

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 ☐

LHHPA001

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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

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 D D M M Y Y Y Y