HIVCare Programme application form

MALCOR MEDICAL AID SCHEME
Administered by Discovery Health

Contact details
Tel: 0860 100 698 • PO Box 8012, Greenstone 1616 • www.malcormedicalaid.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 2022, the latest version of the application form is available on www.malcormedicalaid.co.za

Who we are

The Malcor Medical Aid Scheme (referred to as 'the Scheme'), registration number 1547, 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. 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 7 if you need medicine.
5. Please email this completed and signed form with any support documentation to **HIV_Diseasemanagement@malcormedicalaid.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 100 698 if you have any questions.

1. Patient details

Title | 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)

Gender M F

Telephone (H) | Telephone (W)

Cellphone | Fax

Email address

Outcome of this application must be sent to me by: Email Fax

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.malcormedicalaid.co.za

Patient's name and surname

Policy Number

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

Title | Surname

First name/s (as per identity document)

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

Telephone (H) | Telephone (W)

Cellphone | Fax

Email address

Main member's signature

Date Y Y Y Y M M D D

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 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

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 the doctor)

Name

Telephone Fax

Practice email

BHF practice number

The outcome of this application must be sent to me by Email or 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 Y Y Y Y M M D D

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