Request for pre-exposure prophylaxis (PREP) 2022

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 register for pre-exposure prophylaxis and to apply for antiretroviral prophylaxis medicine. Cover for antiretroviral prophylaxis medicine is available subject to the Scheme Rules and the terms and conditions of the benefit.

This form is valid for 2022.

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. Please make sure the form is completed in full and signed by a healthcare professional.
3. Once complete, please email it to **HIV_Diseasemanagement@malcormedicalaid.co.za**

1. Patient details

Title | Surname

First name/s (as per identity document)

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

Gender M F

Race African | Coloured | Indian/Asian | White | Other

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

Do not want to disclose.

Membership number

Telephone (H) | (W)

Cellphone | Fax

Email address

How would you prefer to receive this letter? Email | Post

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

2. Main member details

Title | Surname

First name/s (as per identity document)

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

Gender M F

Race African | Coloured | Indian/Asian | White | Other

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

Do not want to disclose.

Membership number

Telephone (H) | (W)

Cellphone | Fax

Email address

Main member's signature | Date (Y Y Y Y M M D D)

Patient's name and surname

Membership number

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:

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)

*Require a negative ELISA result < 1 month old before we will approve treatment.

4. Medicine (to be completed by doctor)

Medicine	Dosage	Duration of treatment

Please specify any other medicine that the patient uses regularly

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

Name

BHF Practice number | Speciality

Telephone

Cellphone

Email

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 Malcor Medical Aid Scheme.

Signature of doctor

Date Y Y Y Y M M D D