UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

UKZN MEDICAL SCHEME
Administered by Discovery Health

Contact details
Tel: 0860 11 33 22, PO Box 652509, Benmore 2010, www.discovery.co.za

HIV*Care* Programme application form

This application form is to join the HIVCare Programme and to apply for antiretroviral therapy (ART). Cover for antiretroviral therapy is available through the Chronic Illness Benefit subject to the Scheme's rules.

We will approve antiretroviral medicines are met and based on our list of medicines.

Antiretroviral medicines not on the list will be paid for up to a monthly Chronic Drug Amount. There are some medicines that the Chronic Illness Benefit does not cover. The Scheme will pay for certain multivitamins and vaccines according to the medicine list up to a limit for the year.

Who we are

The University of KwaZulu-Natal Medical Scheme (referred to as 'the Scheme'), registration number 1520, is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as 'we' 'us' and 'our' or 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 application form

A note to the treating healthcare professional

Please remember to send the patient's most recent relevant blood results with this form.

Send the completed and signed form to us by:

- Fax: **011 539 3151**
- Email: **HIV_Diseasemanagement@discovery.co.za**
- Post: PO Box 536, Rivonia, 2128

Please call us on 0860 11 33 22 if you have any questions about your application.

What you must do

Please go through these steps:

Step 1: Fill in section 1 to 2 of the application form.

Step 2: Take the form to your doctor to complete section 3 to 7 if you need medicine.

1. Patient details

Title | Initials | 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)

Relationship to main member | Sex (M F)

Telephone (H) | (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.discovery.co.za

Patient, guardian or parent to sign if the patient is a minor

2. Member information (if patient is a minor)

Title Surname

First names (as per identity document)

Membership number

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

Telephone (H) (W)

Other Fax

Cellphone

Email address

Patient's name and surname

Membership number

Patient, guardian or parent to sign if the patient is a minor

3. Clinical data and examination (to be completed by the doctor)

Note: Investigation results are essential for registration. Please provide copies of recent reports (for the last three months).

Date of last test (Y Y Y Y M M D D)

More pathology investigations will be useful for a full clinical picture. Please provide copies of the following reports:

- Full blood count
- Liver function test
- Urea and creatinine

Is the patient pregnant? Yes ☐ No ☐

If yes, expected date of delivery (Y Y Y Y M M D D)

Height (m) Weight (kg)

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

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

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

2. Clinical information to substantiate staging in point 1

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: A Side effects B Cost C Resistance D Other

If **other**, please provide a brief explanation

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

Patient's name and surname

Membership number

5. Medicine required for HIV and AIDS (to be completed by the doctor)

The HIV*Care* Programme provides cover for disease-modifying therapy. Medicine used for symptomatic control is not covered.

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

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

Name

Telephone

Fax

Practice email

Practice number

The outcome of this application must be sent to me by Email ☐ or Fax ☐

Doctor's signature

Date Y Y Y Y M M D D

Note to doctor: The doctor's fee for completion of this form will be reimbursed on code 0199 provided that the patient is a member of the Scheme at the time of application. Payment of the claim will be made from the member's benefit, subject to the member's Benefit Option and availability of funds. Please also note that the pharmacy will need a new script every six months.

7. Address for delivery of medicine

Contact person

Address

Code

Telephone (H)

(W)

Cellphone

Fax