Medimed
Managing your healthcare security

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HIV APPLICATION FORM

SECTION A: IMPORTANT INFORMATION

1. One application must be completed per beneficiary applying for enrolment on the Scheme's HIV Risk Management Programme.
2. Please submit completed forms as incomplete information may delay registration.
3. Allow 2 working days for the processing of your application once all required information is received.
4. Approval of enrolment on the Medimed HIV programme is subject to the rules of the scheme and managed care protocols.
5. Send completed forms to wellbeing@medimed.co.za or contact the Disease Risk Management team on 086 010 3228 with any queries.

SECTION B: BENEFICIARY DETAILS

Scheme | Option

Title | Initials | First Names | Surname

Medical Aid Number | Identity Number/ Passport Number | Date of Birth (Y Y Y Y M M D D)

Telephone Number (Home) | Cellphone Number

E-mail Address

Postal Address
Street Number / Street Name and Suburb
City and Province | Code

Preferred way of communication *(please tick one option):* Tel (H) ☐ Cellphone ☐ Email ☐

SECTION C: HISTORY

Date of HIV Diagnosis: Y Y Y Y M M D D | Test used:

(Please attach copy of positive test result)

Previous ARV Regime	Date Started	Date Stopped	Reason for Change
	Y Y M M D D	Y Y M M D D	
	Y Y M M D D	Y Y M M D D	
	Y Y M M D D	Y Y M M D D	

Has Client been counselled? Yes ☐ No ☐ | By whom:

Is Client coping with diagnosis? Yes ☐ No ☐

Has Client disclosed HIV diagnosis? Yes ☐ No ☐ | If yes to whom:

Alternate Contact: *(Please confirm an alternative person that we can contact to discuss your care and management if needed)*

Name | Relationship | Cell

HIV option: Pre- ART ☐ HAART ☐ PMTCT ☐ Paed (0 - 15years) ☐ PEP ☐ PrEP ☐

(please note that PrEP is only available for sero-discordant couples on the HIV programme)

Medical Aid Number:

SECTION D: CLINICAL INFORMATION AND EXAMINATION

Note: Investigation results are essential for registration on the Programme. *Please provide copies of all recent pathology reports.*

Current weight kg Height m

Is the member pregnant? Yes ☐ No ☐ If Yes, expected date of delivery Y Y Y Y M M D D

Does member consume alcohol? Yes ☐ No ☐ Does member use traditional/alternative medicines Yes ☐ No ☐

Co-Morbidities:

Does member have any known allergies? Yes ☐ No ☐ If Yes, please provide details:

Please describe any abnormality on examination or previous significant illness:

Baseline Investigations *(all required tests results must accompany application)*

Hepatitis B ☐ Cholesterol ☐ Glucose ☐ Creatinine ☐ U & E ☐ FBC ☐ LFT ☐ RPR ☐ Pap Smear ☐

CRAG ☐ Other ☐ *Please provide details:*

TB Screen: Symptomatic: Yes ☐ No ☐ **Investigations:** CXR: Yes ☐ No ☐ **Sputum:** Yes ☐ No ☐

Is member a candidate for IPT? Yes ☐ No ☐

SECTION E: SEROLOGICAL TESTS

Previous CD4 and Viral Load studies:
(NB - please ensure that a Cryptococcal Antigen test is done for any CD4 count below 100)

CRAG Result

CD4		VIRAL LOAD	
Date	Result	Date	Result
Y Y Y Y M M D D	_____ cells/mm³ CD4% = _____ %	Y Y Y Y M M D D	_____ copies/ml
Y Y Y Y M M D D	_____ cells/mm³ CD4% = _____ %	Y Y Y Y M M D D	_____ copies/ml
Y Y Y Y M M D D	_____ cells/mm³ CD4% = _____ %	Y Y Y Y M M D D	_____ copies/ml

SECTION F: MEDICATION REQUIRED FOR HIV AND AIDS *(to be completed by doctor)*

ICD-10 Code	Medication prescribed *(Name, strength & dosage)*	Date medication initiated & prescriber details	Repeats

Please attach a copy of the prescription.

Medical Aid Number:

SECTION G: MEDICAL PRACTITIONER DETAILS

Surname

Initials

Practice Number

Speciality

Telephone Number

Cellphone Number

Fax number

E-mail Address

The following have been attached to this application: Confirmation of HIV status (ELISA) ☐ CD4 & Viral load result ☐

Hb/ALT/CREATININE ☐ Prescription for medicine ☐

The outcome of this application must be communicated to me via my: email address ☐ OR fax number ☐

Signature of Medical Practitioner:

Date: Y Y Y Y M M D D

SECTION H: DECLARATION

By signing below, I hereby give permission for, acknowledge and /or agree to the following:

- My (or my minor dependant's) health care provider may provide clinical information as requested by Medimed medical scheme.
- HIV benefits as described in the benefit guide are subject to registration on the HIV programme and subject to scheme rules and managed care protocols and guidelines.
- I accept that I have a responsibility to my own health irrespective of the funding decisions made by Medimed medical scheme and all treatment decisions remain the responsibility of the beneficiary's health care provider and should not be affected by the funding decisions subject to scheme rules, clinical criteria or protocols.
- All information concerning this application will remain confidential at all times, Medimed and the contracted Administrator will keep your personal information confidential and will adhere to the Protection of Personal Information Act, 2013 when processing your personal information. Your personal information will be processed for the purpose of the Medical Schemes Act 131 of 1998.

Print Name and Surname

Date: Y Y Y Y M M D D

Patient Signature
(or member if patient is a minor)

Relationship (if guardian)