Contact us
Tel: 0800 BANKMED (0800 226 5633) • Private Bag X2, Rivonia 2128 • www.bankmed.co.za

Request for pre-exposure prophylaxis (PREP)

Who we are

Bankmed (referred to as 'the Scheme'), registration number 1279, 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) which takes care of the administration of your membership for the Scheme.

The preferred provider for GP consultations is the Premier Plus HIV GP Network.

How to complete this form

Step 1: Ensure the form is completed in full and signed by a Healthcare Professional
Step 2: Please return the completed form to us by e-mail to **Hiv@bankmed.co.za**

1. Patient details

Title | Surname

First name/s (as per identity document)

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

Membership number

Telephone (H) | (W)

Cellphone | Fax

E-mail address

The outcome of this application must be sent to me by ☐ E-mail ☐ Fax

Kindly ensure your contact details are always up to date as we rely on this information to keep you updated. You may update your details by logging into www.bankmed.co.za

Patient's signature
(if patient is a minor, Principal Member must sign)

Original hand signature required

Date (D D M M Y Y Y Y)

2. Principal Member details

Title | Surname

First name/s (as per identity document)

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

Membership number

Telephone (H) | (W)

Cellphone | Fax

E-mail address

Patient's signature
(if patient is a minor, Principal Member must sign)

Original hand signature required

Date (D D M M Y Y Y Y)

BANRPP001

3. Clinical data (to be completed by Healthcare Professional)

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. Medication (to be completed by Healthcare Professional)

Diagnosis	Date when condition was first diagnosed	Medication name, strength and dosage	Number of repeats	How long has the patient used this medication?		May the patient use a generic medication?		
				Years	Months	Yes	No	Reason if no
HIV								
Opportunistic infections								

We will approve funding for generic medication where available, unless you have indicated otherwise

Kindly specify any other medication that the patient uses regularly

5. Healthcare Professional's details (to be completed by the Healthcare Professional)

Name

BHF practice number

Telephone

Cellphone

E-mail

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 Bankmed Medical Scheme and Discovery Health (Pty) Ltd.

Signature of Healthcare Professional

Original hand signature required

Date D D M M Y Y Y Y