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

HIV Programme application form

This application form is to join the HIV Programme and to apply for antiretroviral medication. Cover for antiretroviral medication is available through the HIV programme on all Bankmed Plans, subject to the Scheme Rules. The preferred provider for GP consultations is the Premier Plus HIV GP network of Healthcare Professionals. Please use the latest version of the medicine lists (formularies) that are available on www.bankmed.co.za

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.

How to complete this form

A note to the treating Healthcare Professional:
Kindly remember to send the patient's most recent relevant blood results with this form.

1. Please use one letter per block, complete in black ink and print clearly**.**
2. You (the member) must complete Section 1, 2 and 3 of this form**.**
3. Your Healthcare Professional must complete Section 4 and 5 and include detailed documents supporting your application**.**
4. Please e-mail this completed and signed form with any support documentation to **HIV@bankmed.co.za** or fax it to 011 539 3151 or post it to Bankmed, Private Bag X2, Rivonia 2128**.**
5. A dedicated case manager will call you and your treating Healthcare Professional to let you know about our funding decision and the process to follow if your application is approved**.**
6. You can also contact our call centre on 0800 BANKMED (0800 226 5633) if you have any questions**.**

Section 1: Principal Member details (to be completed by the member)

Title

First names

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

Membership number

Telephone (H) (W)

Cellphone Fax

E-mail address

Section 2: Patient details (to be completed by the patient or the member)

Title Surname

First name/s

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

Telephone (H) (W)

Cellphone Fax

E-mail address

Preferred postal address

Code

Section 3: Patient consent (to be signed by the member or guardian should the patient be a minor)

1. I acknowledge that Discovery Health Pty Ltd is the administrator of the Programme and that any antiretroviral treatment prescribed, as well as the general management of my HIV condition, will be the sole responsibility of my Healthcare Professional(s), in consultation with me. Discovery Health and Bankmed Medical Scheme ("Bankmed") (collectively, the "Bankmed Parties") will accordingly not be liable for any claims by me or my dependants arising from the implementation of the Programme, save insofar as provided in the Bankmed Rules.
2. I hereby give my consent to the Bankmed Parties and its staff to obtain my Special Personal Information (i.e. health and biometric) from my Healthcare Professionals (pharmacy, pathology, medical doctor, radiology), to assess my medical risk and enrol me on the Bankmed Special Care: HIV Programme and to use such information to my benefit. I understand and agree that Special Personal Information, including medical information relevant to my current state of health, can be disclosed to third parties for the purpose of scientific, epidemiological and/or financial analysis, without disclosure of my identity. I furthermore agree to the Programme's case managers sharing my Special Personal Information with any other healthcare provider involved in my care (including the Hospital Advisory Services professionals appointed by Bankmed).
3. I understand that no information regarding my case will be made available to my employer(s) or any other person not directly involved in my care.
4. I give my consent to the Bankmed Parties to electronically store, access, process and retain my Special Personal Information for the purposes set out in this document as may otherwise be required to administer the Programme. By giving my consent in this document, I acknowledge that the Bankmed Parties and my healthcare provider(s) will be entitled to access, store, process and/or retain my Special Personal Information.
5. Whilst the Bankmed Parties will use their best endeavours to uphold the confidentiality of all my Special Personal Information, the Bankmed Parties will not be liable for any claims by me or my dependants arising from any unauthorised disclosure of my Special Personal Information to a third party.
6. I can terminate my participation in the Bankmed Special Care: HIV Programme at any time with immediate effect on notice to a Bankmed Party, but understand that all benefits that I enjoyed under the Programme shall immediately cease and the Scheme shall not be obliged to reinstate such benefits at any time thereafter.
7. I acknowledge that, should I not comply with the Bankmed Special Care: HIV Programme protocols or prescribed treatment, Bankmed, in its sole discretion, may elect to exercise its rights and limit any benefits to the prescribed minimum benefits (PMBs), always subject to the applicable legislation and the Bankmed Rules.
8. I understand that telephone calls will be recorded for internal clinical quality assurance purposes and will not be shared outside of the Bankmed Special Care: HIV Programme unit.
9. I understand and acknowledge that "consent", for the purposes of this document, means my informed consent, in other words:
   9.1. I have read and understood the contents of this document.
   9.2. I understand and acknowledge the nature of the Special Personal Information that will be made available to and disclosed, used, processed and retained by Service Providers, as set out in this consent.
   9.3. I understand and acknowledge the purpose for which the Special Personal Information relating to me will be made available to, and disclosed, used, processed and retained by the Bankmed Parties and my healthcare provider(s), as set out in this consent.
   9.4. I have the legal capacity to give my informed consent, in other words, I am over the age of 18 years and am able to fully understand and make decisions about my healthcare.

I acknowledge that my details provided above are treated as confidential and I accept that the HIV Programme may use these contact details to communicate with me.

Signed Parent/Guardian (member) _____ Date D D M M Y Y Y Y

Full name of Parent/Gaurdian (member) _____

Section 4: General patient information (to be completed by the Healthcare Professional)

Date of diagnosis D D M M Y Y Y Y

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

- CD4 count
- Viral load
- Full blood count
- Liver function test
- Urea and creatinine

Height ___ m Weight ___ kg BSA ___

Significant past medical history, including opportunistic infections

Operation/hospital admissions (especially if related to HIV infection)				
Medical				
Surgical				
Obstetric				
Gynaecologic				

Significant past medical history, including opportunistic infections

Allergies				
Psychiatric				
Alcohol use				
Concomitant drug use				
Other				
Diabetes				
Hypercholesterolemia				
Depression/psychiatric care				
Cancer - chemotherapy				
Chronic renal failure				
Hypertension/cardiac failure (beta blockers or calcium channel blockers)				
Epilepsy				
Other meds i.e Warfarin, steroids				

OBSTETRIC HISTORY

Grav: Para:

Date of confinement Y Y Y Y M M D D Planned mode of delivery: Normal Vaginal delivery Caesarean section

Currently pregnant? Yes No Estimated delivery date Y Y Y Y M M D D

Desire to become pregnant? Yes No Contraception practised/practising

ALLERGIES

Drugs: Other:

SYMPTOMS EXPERIENCED BY PATIENT OVER PAST SIX MONTHS

WHO Clinical Stage 3 symptoms		**WHO Clinical Stage 4 symptoms**	
Unexplained severe weight loss (>10% of body weight)		HIV wasting syndrome	
Unexplained chronic diarrhoea > one month		Pneumocystis pneumonia	
Unexplained persistent fever > one month		Recurrent severe bacterial pneumonia	
Persistent oral candidiasis		Chronic herpes simplex infection (oralabial, genital or onorectal of more than one month's duration or visceral at any site)	
Oral hairy leukoplakia		Oesophageal candidiasis (or candidiasis of trachea, bronchi or lungs	
Pulmonary tuberculosis		Extrapulmonary tuberculosis	
Severe bacterial infections (e.g. pneumonia)		Kaposi's sarcoma	
Acute nectrotising ulcerative stomatitis, gingivitis or periodontis		Cytomegalovirus infection (retinitis or infection of other organs)	
Unexplained anaemia, neutropaenia, chronic thrombocytopaenia		Ventral nervous system toxoplasmosis	
Clinical Stage 3 – Paediatric		HIV encephalopathy	
Unexplained moderate malnutrition		Extrapulmonary cryptococcosis including meningtis	
Unexplained persistent diarrhoea (4 days or more)		Disseminated non-tuberculous mycobacteria infection	

SYMPTOMS EXPERIENCED BY PATIENT OVER PAST SIX MONTHS

Persistent fever > one month		Progressive multifocal leucoencephalopathy	
Persistent oral candidiasis (after first six weeks of life)		Chronic cryptosporidiosis	
Acute necrotising ulcerative gingivitis or periodontitis		Chronic isosporiasis	
Lymph node tuberculosis		Disseminated mycosis (extrapulmonary histoplasmosis, coccidiomycosis)	
Weakness, numbness or paraesthasias in hands or feet		Recurrent septicaemia (including non-typhoidal salmonella)	

Has your patient been investigated or treated for TB? Yes No Date TB treatment started: D D M M Y Y Y Y

Treatment/Details:

Body mass: kg Height: cm CDC or WHO classification category:

Previous CD4 and viral load studies

CD4				Viral load			
Date	Result	Date	Result	Date	Result	Date	Result

Treatment	Date	Result
U&E – Pt on tenofivir		
LFT – Pt on nevirapine		
FBC – Pt on zidovudine		

Previous antiretroviral therapy (ART) and HIV related prophylaxis

Medication	Dose	Date commenced	Date stopped	Reason stopped/side-effects

Current ART, prophylaxis and chronic medication

Medication	Dose	Date commenced	Date stopped	Reason stopped/side-effects

Has the patient been compliant with antiretroviral therapy? Yes No

Detail/reason for non-compliance:

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 medicine?		
				Years	Months	Yes	No	Reason if No
HIV								
Opportunistic infections								

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

Please note: Medikredit preferred pharmacy network is the Designated Service Provider for HIV medication. Include a prescription for the medication recommended for treatment.

Attachments: Copies of the following are to be attached to this application:

Confirmation of HIV status (ELISA) ☐ CD/Viral load results/FBC/ALT/CREATININE ☐ Prescription for medication recommended ☐

Section 5: Healthcare Professional's details and consent

Surname Initials

Practice number Speciality

Physical address

Postal Code

Telephone No. Fax

Cellphone

E-mail

Preferred means of communication E-mail ☐ Fax ☐

I confirm that the clinical details described in this document are to my knowledge accurate and correct. I understand that the Bankmed Medical Scheme HIV treatment protocols are guidelines only and that the ultimate responsibility regarding antiretroviral therapy and general management of my patient's HIV condition will reside with me. The reimbursement of therapy and related costs by the Scheme will be in accordance with the guidelines as well as the benefit available to the above patient from time to time.

Healthcare Professional's signature

Date D D M M Y Y Y Y