ENGEN Medical Benefit Fund

Administered by Discovery Health

Contact details
Tel: 0800 001 615 • PO Box 652509, Benmore 2010 • www.engenmed.co.za

Request for pre-exposure prophylaxis (PREP)

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 Fund Rules and the terms and conditions of the benefit.

Who we are

Engen Medical Benefit Fund, registration number 1572, is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, is a separate company, an authorised financial services provider and is responsible for the administration of your membership on behalf of the Fund.

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@engenmed.co.za** or fax to **011 539 3151**.

Consent for processing my personal information

I give the Fund and the administrator consent to have access to and process all information (including general, personal, medical or clinical information) that is relevant to this application. I understand that this information will be used for the purposes of applying for and assessing my funding request for the PREP benefit. I consent to the Fund and the administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical information) to my healthcare provider and to relevant third parties, to administer the PREP Benefit as well as undertake managed care interventions related to the benefit.

1. Patient details

Title ______ Initial(s) ______

First name(s) ______

Surname ______

Membership number ______

ID or passport number ______

Telephone (H) ______ Telephone (W) ______

Cellphone ______

E-mail ______

Relationship to main member ______

Please ensure your contact details are always up to date as we rely on this information to send you important information. You may update your details on www.engenmed.co.za.

2. Main member details (Please ONLY complete this section if the patient is a minor)

Membership number ______

ID or passport number ______

Member's name ______

Member's surname ______

E-mail ______

Patient's signature ______ Date D D M M Y Y Y Y

If patient is a minor,main member must sign

Please note that this form expires on 31/03/2025. Up to date forms are available on www.engenmed.co.za

EMBRPP001

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

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

Name

BHF practice number

Telephone

Cellphone

E-mail address

I acknowledge that:

1. The approval of this treatment is subject to the HIV status of the patient, and that
2. I have received the patient's consent to disclose their HIV status and any other related information to Engen Medical Benefit Fund and Discovery Health (Pty) Ltd.

Consent withdrawal for your Disease Management Benefits

Withdrawing consent for your general, personal, medical or clinical information to be accessed or shared with relevant third parties, means that you will no longer have access to funding from the applicable disease management benefits. Claims which would usually be funded from the disease management benefits will, once consent is withdrawn, be funded from other available benefits according to the rules of your plan. Should you wish to continue with the consent withdrawal process, then please email **hivdiseasemanagement@discovery.co.za**.

Signature of doctor

Date D D M M Y Y Y Y

Please only sign if information is true, complete and correct.