ENGEN Medical Benefit Fund

Administered by Discovery Health

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

HIV Programme application form

This application form is to join the HIV Programme and to apply for antiretroviral medicine. Cover for antiretroviral medicine is available subject to the Fund Rules and the terms and conditions of the HIV Programme.

Who we are

Engen Medical Benefit Fund (referred to as 'EMBF'), registration number 1572, is a not-for-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the administrator') 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

What you must do

1. Please use one letter per block, complete in black ink and print clearly.
2. You (the patient) must complete Section 1 to 2 of this form and sign section 2.
3. Your doctor must complete Section 3 to 6 if you need medicine.
4. **A note to the treating healthcare professional**: Please remember to send the patient's most recent relevant blood results with this form.
5. Please email this completed and signed form with any support documentation to **HIV@engenmed.co.za** or fax it to **011 539 3151** or post it to **PO Box 536, Rivonia, 2128.**

1. Patient details

Title | Surname

First name/s

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

Gender M F | Membership Number

Telephone (H) | (W)

Cellphone | Fax

Email address

The 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 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)

Title | Surname

First name/s

Membership number

ID or passport number | Gender M F

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

Telephone | (W)

Cellphone | Fax

Email address

Patient's signature (if patient is a minor, main member must sign)

EMBHPA001

Please note that this form expires on 31/03/2023. Up to date forms are available on www.engenmed.co.za.

Date D D M M Y Y Y Y

Patient's name and surname

Membership Number

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

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

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

Is the patient pregnant? Yes ☐ No ☐

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

Height (cm) Weight (kg)

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

Date of diagnosis D D M M Y Y Y Y

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

4.2 Clinical information to substantiate staging in point 1

4.3 Medicine history

Medicine	Duration of treatment	Please insert reason or code (detailed below) for discontinuation of previous antiretroviral therapy

Reason or code for discontinuation: Side effects ☐ Cost ☐ Resistance ☐ Other ☐

If other, please provide a brief explanation

4.4 Is the patient being treated for one or more of the below conditions (please check the appropriate block):

Diabetes ☐ Epilepsy ☐ Hypercholesterolemia ☐ Depression/psychiatric treatment ☐ Tuberculosis (TB) ☐ Cancer ☐

Chronic renal failure ☐ Hypertension/Cardiac failure ☐ Other ☐

4.5 If “other”, please provide a brief explanation

4.6 List the medicine the patient is currently taking for the above condition/s (if applicable)

Patient's name and surname

Membership number

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

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
HIV							
Opportunistic infections							

Patient's name and surname

Membership number

6. Treating healthcare professional's details (to be completed by the doctor)

Name

BHF practice number

Telephone

Cellphone number

Fax

Email 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.

Signature of doctor

Date D D M M Y Y Y Y

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