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.

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

Date of birth (D D M M Y Y Y Y) | ID Number

Gender M F | Membership Number

Telephone | (W)

Cellphone | Fax

Email address

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

Date (D D M M Y Y Y Y)

Patient's name and surname

Membership Number

EMBRPP001

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

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

5. 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.