Administered by Discovery Health

Contact details
Tel: 0860 123 077 • PO Box 652509, Benmore 2010 • www.tfgmedicalaidscheme.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 prophylaxis antiretroviral medicine is available subject to the Scheme Rules and the terms and conditions of the benefit.
This form is valid for 2021.

Who we are

TFG Medical Aid Scheme (referred to as 'the Scheme'), registration number 1578, 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). We take care of the administration of your membership for the Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. To avoid administration delays, please ensure this application is completed in full.
3. Once complete, please email it to HIV_Diseasemanagement@discovery.co.za

1. Patient details

Title ________ Surname ________

First name/s ________

Date of birth Y Y Y Y M M D D ID or passport number ________

Sex M ☐ F ☐ Membership number ________

Telephone (H) ________ (W) ________

Cell phone ________ Fax ________

Email address ________

How would you prefer to receive this letter? Email ☐ Post ☐

Please ensure your contact details are always up to date as we rely on this information to keep you updated. You may update your details on www.discovery.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 Y Y Y Y M M D D ID or passport number ________

Sex M ☐ F ☐ Membership number ________

Telephone (H) ________ (W) ________

Cell phone ________ Fax ________

Email address ________

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

(if patient is a minor, main member must sign)

Patient's name and surname ________

Membership number ________

TFGRPP001

The latest version of the application form is available on www.tfgmedicalaidscheme.co.za.
Alternatively members can phone 0860 123 077 and health professionals can phone 0860 44 55 66.

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 name	Dosage	Duration	May the patient use generics		If no, reason
			Yes	No	

Please specify any other medicine that the patient uses regularly

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

Name

BHF practice number

Telephone

Cellphone

Email

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 TFG Medical Aid Scheme and Discovery Health (Pty) Ltd.

Signature of doctor

Date D D M M Y Y Y Y

Original hand signature required

TFG Medical Aid Scheme is a registered medical scheme and regulated by the Council for Medical Schemes (CMS). The CMS contact details are as follows:
Email: complaints@medicalschemes.co.za | Customer Care Centre: 0861 123 267 | Website: www.medicalschemes.co.za

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