TFG MEDICAL AID SCHEME

Administered by Discovery Health

**Contact details**
Tel: 0860 123 077 • PO Box 652509, Benmore 2010 • www.tfgmedicalaidscheme.co.za

# HIVCare Programme application form

This application form is to join the HIVCare Programme and to apply for antiretroviral medicine. Cover for antiretroviral medicine is available subject to the Scheme rules and the terms and conditions of the HIVCare Programme.

This form is valid for 2023, the latest version of the application form is available on www.tfgmedicalaidscheme.co.za

If you are registered on the TFG Health benefit plan, you must use choose a doctor who is on both the KeyCare network and Premier Plus HIV GP Network to avoid a 20% co-payment. In 2023, if you are registered for a chronic condition, you will be prompted to nominate a primary care network doctor according to your chosen health plan. This nomination process will not impact your benefits and cover in 2023. We will share communication during the course of 2023 to explain:
- The process to follow to nominate your primary care doctor (GP).
- How to change your nominated GP, if necessary.

Members registered on both TFG Health and TFG Health Plus benefit plans need to make use of a HIV DSP Pharmacy to avoid a 20% co-payment. Please log on to www.tfgmedicalaidscheme.co.za to confirm a DSP pharmacy near you or make use of MedXpress.

**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. A note to the treating healthcare professional: Please remember to send the patient's most recent relevant blood results with this form.
3. You (the member) must complete Section 1 to 2 of this form and sign section 2.
4. Your doctor must complete Section 3 to 6 if you need medicine.
5. Please email this completed and signed form with any support documentation to **HIV_Diseasemanagement@discovery.co.za** or fax it to **011 539 3151** or post it to **PO Box 536, Rivonia, 2128**.
6. You can also contact our call centre on **0860 123 077** if you have any questions.

## 1. Patient details

Title

Surname

First name/s

Date of birth Y Y Y Y M M D D

ID or passport number

Gender M F

Membership number

Work

Cell phone

Email address

**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.tfgmedicalaidscheme.co.za**

Patient's name and surname

Membership number



Please note that this form expires on 31/03/2024. Up to date forms are available on www.tfgmedicalaidscheme.co.za.
Alternatively members can phone 0860 123 077 and health professionals can phone 0860 44 55 66.

## 2. Member information (if patient is a minor)

Title

Surname

First name/s

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

Work  Cell phone

Email address

Patient's signature  Date (D D M M Y Y Y Y)

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

## 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

Height (cm)  Weight (kg)

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

Date of diagnosis

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

4.2. Clinical information to substantiate staging in point 1

4.3. Drug 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)

The HIVCare Programme provides cover for disease-modifying therapy. Medicine used for symptomatic control is not covered.

| 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 | | | | | | | |
| | | | | | | | |
| | | | | | | | |

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

## 6. 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

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