Contact us
Tel: 0800 BANKMED (0800 226 5633) • Private Bag X2, Rivonia 2128 • www.bankmed.co.za

HIV Programme application form

This application form is to join the HIV Programme and to apply for antiretroviral medication. Cover for antiretroviral medication is available through the HIV Programme on all Bankmed Plans, subject to the Scheme Rules. The preferred provider for GP consultations is the Premier Plus HIV GP network of Healthcare Professionals. Please use the latest version of the medicine lists (formularies) that are available on **www.bankmed.co.za**.

Who we are
Bankmed (referred to as 'the Scheme'), registration number 1279, 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) which takes care of the administration of your membership for the Scheme.

A note to the treating Healthcare Professional:
Kindly remember to send the patient's most recent and relevant blood results with this form.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly, or complete the form digitally.
2. You (the member) must complete Section 1, 2 and 3 of this form
3. Your Healthcare Professional must complete Section 4 and 5 and include detailed documents supporting your application
4. Please e-mail this completed and signed form with any supporting documentation to **HIV@bankmed.co.za** or post it to Bankmed, **Private Bag X2, Rivonia 2128**
5. A dedicated case manager will call you and your treating Healthcare Professional to let you know about our funding decision and the process to follow if your application is approved
6. You can also contact our call centre on **0800 BANKMED (0800 226 5633)** if you have any questions

Section 1: Principal member details

Membership number

ID or passport number

Member's name

Member's surname

Section 2: Patient details (to be completed by the patient or the member)

Title | Initials

Surname

First name(s)

ID or passport number | Membership number

Telephone (H) | Telephone (W)

Cellphone

E-mail

Relationship to Principal Member

Section 3: Patient consent (to be signed by the principal member or guardian if the patient is a minor)

1. I acknowledge that Discovery Health (Pty) Ltd is the administrator of the Programme and that any antiretroviral treatment prescribed, as well as the general management of my HIV condition, will be the sole responsibility of my Healthcare Professional(s), in consultation with me. Discovery Health and Bankmed Medical Scheme ("Bankmed") (collectively, the "Parties") will accordingly not be liable for any claims by me or my dependants arising from the implementation of the Programme, save insofar as provided in the Bankmed Scheme Rules
2. I hereby give my consent to the Parties and its staff to obtain my Special Personal Information (i.e. health and biometric) from my Healthcare Professionals (pharmacy, pathology, medical doctor, radiology), to assess my medical risk and enroll me on the Bankmed HIV Programme and to use such information to my benefit. I understand and agree that Special Personal Information, including medical information relevant to my current state of health, can be disclosed to third parties for the purpose of scientific, epidemiological and/or financial analysis, without disclosure of my identity. I furthermore agree to the Programme's case managers sharing my Special Personal Information with any other Healthcare Professional involved in my care (including the Hospital Advisory Services professionals appointed by Bankmed)
3. I understand that no information regarding my case will be made available to my employer(s) or any other person not directly involved in my care
4. I give my consent to the Parties to electronically store, access, process and retain my Special Personal Information for the purposes set out in this document as may otherwise be required to administer the Programme. By giving my consent in this document, I acknowledge that the Parties and my Healthcare Professional(s) will be entitled to access, store, process and/or retain my Special Personal Information
5. While Bankmed ensures that the confidentiality of all personal information, the parties will not be liable for any claims by me or my dependants arising from any unauthorised disclosure of my Special Personal Information to a third party
6. I can terminate my participation in the Bankmed HIV Programme at any time with immediate effect on notice to Bankmed, but understand that all benefits that I enjoyed under the Programme shall immediately cease and the Scheme shall not be obliged to reinstate such benefits at any time thereafter
7. I acknowledge that, should I not comply with the Bankmed HIV Programme protocols or prescribed treatment, Bankmed, in its sole discretion, may elect to exercise its rights and limit any benefits to the Prescribed Minimum Benefits (PMBs), always subject to the applicable legislation and the Bankmed Scheme Rules
8. I understand that telephone calls will be recorded for internal clinical quality assurance purposes and will not be shared outside of the Bankmed HIV Programme unit
9. I understand and acknowledge that "consent", for the purposes of this document, means my informed consent, in other words:
   9.1. I have read and understood the contents of this document
   9.2. I understand and acknowledge the nature of the Special Personal Information that will be made available to and disclosed, used, processed and retained by Service Providers, as set out in this consent
   9.3. I understand and acknowledge the purpose for which the Special Personal Information relating to me will be made available to, and disclosed, used, processed and retained by the parties and my Healthcare Professional(s), as set out in this consent
   9.4. I have the legal capacity to give my informed consent, in other words, I am over the age of 18 years and am able to fully understand and make decisions about my healthcare
10. 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 **HIV@bankmed.co.za**.

I acknowledge that my details provided above are treated as confidential and I accept that the HIV Programme may use these contact details to communicate with me.

Signed by Principal Member (or Adult Dependent) _____ Date D D M M Y Y Y Y

Full name of Principal Member (or Adult Dependent) _____

Section 4: General patient information (to be completed by the Healthcare Professional)

Date of diagnosis D D M M Y Y Y Y

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

1. CD4 count 2. Viral load 3. Full blood count 4. Liver function test 5. Urea and creatinine

Height ___ m Weight ___ kg BSA ___

Significant past medical history, including opportunistic infections

Operation/hospital admissions (especially if related HIV infection)	
Medical	
Surgical	
Obstetric	
Gynaecologic	

Significant past medical history, including opportunistic infections

Allergies	
Psychiatric care	
Alcohol use	
Concomitant drug use	
Other	
Diabetes	
Hypercholesterolemia	
Depression	
Cancer - chemotherapy	
Chronic renal failure	
Hypertension/cardiac failure (beta blockers or calcium channel blockers)	
Epilepsy	
Other meds i.e. Warfarin, steroids	

OBSTETRIC HISTORY

Grav: Para:

Currently pregnant? Yes No Estimated delivery date Y Y Y Y M M D D

Desire to become pregnant? Yes No Contraception practised/practising

Date of confinement D D M M Y Y Y Y Planned mode of delivery: Normal vaginal delivery Caesarean section

ALLERGIES

Drugs: Other:

SYMPTOMS EXPERIENCED BY PATIENT OVER PAST SIX MONTHS

WHO Clinical Stage 3 symptoms		**WHO Clinical Stage 4 symptoms**	
Unexplained severe weight loss (>10% of body weight)		HIV wasting syndrome	
Unexplained chronic diarrhoea > one month		Pneumocystis pneumonia	
Unexplained persistent fever > one month		Recurrent severe bacterial pneumonia	
Persistent oral candidiasis		Chronic herpes simplex infection (oralabial, genital or onorectal of more than one month's duration or visceral at any site)	
Oral hairy leukoplakia		Oesophageal candidiasis (or candidiasis of trachea, bronchi or lungs)	
Pulmonary tuberculosis		Extrapulmonary tuberculosis	
Severe bacterial infections (e.g. pneumonia)		Kaposi's sarcoma	
Acute nectrotising ulcerative stomatitis, gingivitis or periodontis		Cytomegalovirus infection (retinitis or infection of other organs)	
Unexplained anaemia, neutropaenia, chronic thrombocytopaenia		Ventral nervous system toxoplasmosis	
Clinical Stage 3 – Paediatric		HIV encephalopathy	
Unexplained moderate malnutrition		Extrapulmonary cryptococcosis including meningtis	
Unexplained persistent diarrhoea (4 days or more)		Disseminated non-tuberculous mycobacteria infection	
Persistent fever > one month		Progressive multifocal leucoencephalopathy	

SYMPTOMS EXPERIENCED BY PATIENT OVER PAST SIX MONTHS

Persistent oral candidiasis (after first six weeks of life)		Chronic cryptosporidiosis	
Acute necrotising ulcerative gingivitis or periodontitis		Chronic isosporiasis	
Lymph node tuberculosis		Disseminated mycosis (extrapulmonary histoplasmosis, coccidiomycosis)	
Weakness, numbness or paraesthasias in hands or feet		Recurrent septicaemia (including non-typhoidal salmonella)	

Has your patient been investigated or treated for TB? Yes No Date TB treatment started: D D M M Y Y Y Y

Treatment/Details:

CDC or WHO classification category

Previous CD4 and viral load studies

CD4				Viral load			
Date	Result	Date	Result	Date	Result	Date	Result

Treatment	Date	Result
U&E – Pt on tenofivir		
LFT – Pt on nevirapine		
FBC – Pt on zidovudine		

Previous antiretroviral therapy (ART) and HIV related prophylaxis

Medication	Dose	Date commenced	Date stopped	Reason stopped/side-effects

Current ART, prophylaxis and chronic medication

Medication	Dose	Date commenced	Date stopped	Reason stopped/side-effects

Has the patient been compliant with antiretroviral therapy? Yes No

Detail/reason for non-compliance:

Diagnosis	Date when condition was first diagnosed	Medication name, strength and dosage	Number of repeats	How long has the patient used this medication?		May the patient use a generic medicine?		
				Years	Months	Yes	No	Reason if No
HIV								
Opportunistic infections								

Please note: The Bankmed Pharmacy Network is the Designated Service Provider for HIV medication. Include a prescription for the medication recommended for treatment.

Attachments: Copies of the following are to be attached to this application:

Confirmation of HIV (ELISA) ☐ CD/Viral load results/FBC/ALT/CREATININE ☐ Prescription for medication recommended ☐

Section 1: Principal member details

Membership number

ID or passport number

Member's name

Member's surname

Section 5: Healthcare Professional's details and consent

Surname Initials

Practice number Speciality

Telephone No.

Cellphone

E-mail

I confirm that the clinical details described in this document are to my knowledge accurate and correct. I understand that the Bankmed Medical Scheme HIV treatment protocols are guidelines only and that the ultimate responsibility regarding antiretroviral therapy and general management of my patient's HIV condition will reside with me. The reimbursement of therapy and related costs by the Scheme will be in accordance with the guidelines as well as the benefit available to the above patient from time to time.

Healthcare Professional's signature

Date D D M M Y Y Y Y