

HIVCare Programme application form

Contact details

Tel: 0860 103 933 • PO Box 652509, Benmore 2010 • www.lahealth.co.za

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

If you are on the LA Comprehensive, LA Core, LA Active or LA Focus option, you must use a Premier Plus HIV Network GP to manage your condition to avoid a 20% co-payment on consultations.

If you are on the LA KeyPlus option, you must make use of a KeyCare Network GP who is your nominated primary care provider to avoid a 20% co-payment on consultations. Additionally, if you are on the LA KeyPlus option, please confirm a Designated Service Provider pharmacy near you on www.lahealth.co.za.

Please always look at the latest version of the medicine lists available at www.lahealth.co.za.

Who we are

LA Health Medical Scheme (referred to as 'the Scheme'), registration number 1145, 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. Please remember to send your 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@lahealthms.co.za or post it to PO Box 536, Rivonia, 2128.
6. You can also contact our call centre on **0860 103 933** if you have any questions.

Consent for processing your personal information

I give the Scheme and the administrator consent to have access to and process all information (including general, personal, medical or clinical information) that is relevant to this application. I understand that this information will be used for the purposes of applying for and assessing my funding request for the HIV benefit. I consent to the Scheme and the administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical information) to my healthcare provider and to relevant third parties, to administer the HIV Benefit as well as undertake managed care interventions related to the chronic condition.

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 benefit option.

Should you wish to continue with the consent withdrawal process, then please email HIV_Diseasemanagement@lahealthms.co.za.

1. Patient details

Title	<input type="text"/>	Surname	<input type="text"/>
First name/s	<input type="text"/>		
ID or passport number	<input type="text"/>		
Gender	M <input type="checkbox"/>	F <input type="checkbox"/>	Date of birth <input type="text"/>
Membership number	<input type="text"/>	Telephone	<input type="text"/>
Work	<input type="text"/>	Cellphone	<input type="text"/>
Email	<input type="text"/>		

Please ensure your contact details are always up to date as we rely on this information keep you updated. You may update your details on www.lahealth.co.za

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

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	Reason if 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 doctor)

Name

Telephone

Practice email

Practice number

I confirm that I have received the patient's consent to disclose their HIV status and other medical information in this form to the Scheme and Discovery Health (Pty) Limited.

Doctor's signature

Date