HIV Care Programme application form 2025

Discovery Health Medical Scheme

Who we are

Discovery Health Medical Scheme, registration number 1125, is a not-for-profit organisation registered with the Council for Medical Schemes, and is the medical scheme that you are a member of.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Discovery Health Medical Scheme and takes care of the administration of your membership.

Contact us

Tel (members): **0860 99 88 77**, Tel (health partners): **0860 44 55 66**, **www.discovery.co.za**, PO Box 784262, Sandton, 2146, 1 Discovery Place, Sandton, 2196

Purpose of the form

This application form is to join the HIV Care Programme and to apply for antiretroviral medicine. Please always look at the latest version of the medicine lists available at **www.discovery.co.za** > under Medical Aid > Find documents and certificates.

What you must do

- Fill in the form in black ink and print clearly or complete the form digitally. You can view the list of approved digital signature providers on **www.discovery.co.za**, under Medical Aid > Find documents and certificates > Application forms.
- Fill in section 1 and 2 of the application form and sign both sections. The patient or main member on behalf of a minor, must sign and date any changes.
- Take the form to your doctor to complete section 3 to 6 if you need medicine.
- Once we receive the application form for the medicine you need, we will call you to confirm your order.
- There is overwhelming medical evidence that patients experience improved health outcomes when their primary care is coordinated through a single primary care GP. In line with this best practice, for members on all health plans except the Executive Plan, you and your dependants need to nominate a primary care GP for the effective management of your chronic conditions. If you are on any health plan except the Executive Plan, when you visit your nominated network GP for the management of your chronic condition, we'll cover the consultation at 100% of the Discovery Health Rate (DHR). If you see a GP who is not your nominated primary care GP, or your nominated GP is not a network GP, you will be responsible for any co-payments. You and your dependants can change your nomination three times every calendar year. Nominate your GP or manage your existing nomination on **www.discovery.co.za** > Medical aid > Nominate a primary care GP.

Consent for processing my 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. You can view and read our Privacy Statement on **www.discovery.co.za** > Medical aid > **About Discovery Health Medical Scheme**.

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_Diseasemanagement@discovery.co.za**.

A note to the treating healthcare professional

Please remember to send the patient's most recent and relevant blood results with this form. Send the completed and signed form to us by email **HIV_Diseasemanagement@discovery.co.za** or post to **PO Box 536, Rivonia, 2128,** or you can submit this form on **www.discovery.co.za** under Medical Aid > Get Help > Submit a document and follow the guided steps through our Virtual Agent.

1. Patient details

Title		Initials	
Surname			
First name(s)			
Membership number		ID or passport number	
Telephone (H)		Telephone (W)	
Cellphone			
Email			

Relationship to main member

Patient's signature

Date D D M M Y Y Y Y

(if patient is a minor, parent/guardian to sign)

2. Main member details

Membership number

ID or passport number

Member's name

Member's surname

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 latest 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 D D M M Y Y Y Y

Height (m) Weight (kg)

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

Date of diagnosis D D M M Y Y Y Y

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

4.2. Clinical information to substantiate staging in point 4.1

4.3 Medicine history

Medicine	**Duration of treatment**	**Please insert reason or code (detailed below) for discontinuation of previous antiretroviral therapy**

Reason or code for discontinuation: A) Side effects B) Cost C) Resistance D) Other

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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)

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

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 generic medicine?		Reason if no
				Years	Months	Yes	No	
HIV								
Opportunistic infections								

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

First name(s)

Surname

BHF practice number

Billing practice number

Practice number

Telephone

Email

The outcome of this application will be communicated to you by 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 Discovery Health Medical 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.