

Contact details

Tel: 0860 002 107 • PO Box 652509, Benmore 2010 • www.bemas.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 2024, the latest version of the application form is available on www.bemas.co.za

Who we are

The BMW Employees Medical Aid Society (referred to as 'BEMAS'), registration number 1526, is a not-for-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 BEMAS.

How to complete this form

Please ensure that all the relevant information required, as set out in the form is completed, including contact details for the provider and date of request.

1. Please use one letter per block, complete in black ink and print clearly.
2. 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.
4. Your doctor must complete Section 3 to 6, and include detailed documents supporting your application.
5. Please email this completed and signed form with any support documentation to HIV_Diseasemanagement@bemas.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 002 107** if you have any questions.

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.

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@bemas.co.za.

1. Patient details

Title	<input type="text"/>	Initials	<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 <input type="text"/>
Membership number	<input type="text"/>		
Telephone	<input type="text"/>	Work	<input type="text"/>
Cellphone	<input type="text"/>		<input type="text"/>
Email address	<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.bemas.co.za

BEMHPA001

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 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 Medicine history

Medicine	Duration of treatment	Please insert reason or code (detailed below) for discontinuation of previous antiretroviral therapy
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

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?

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

