YourLife PROGRAMME

PG GROUP MEDICAL SCHEME

APPLICATION FORM

PLEASE USE BLOCK LETTERS FOR ALL SECTIONS

1. MEMBER AND PATIENT INFORMATION

TO BE COMPLETED BY THE APPLICANT

MAIN MEMBER DETAILS

Membership number

Title | Initials | ID number

Full name and surname

Email address

PATIENT DETAILS

Dependant code

Title | Initials | ID number

Full name and surname

Please provide **preferred** contact details for confidential correspondence.

Contact numbers | Home | Work

Cell phone

Postal address

Postal code

☐ My delivery address (for medication) is the same as my postal address

Delivery address for medication

Postal code

Email address

PATIENT CONSENT

I understand that PG Group Medical Scheme and Momentum Health Solutions (Pty) Ltd, the Administrator, will maintain the confidentiality of my personal information and comply with the Protection of Personal Information Act 4 of 2013 (POPIA) and all existing data protection legislation, when collecting, processing and storing my personal information for the purposes of registration on the YourLife Programme.

I understand that:

- Funding for this benefit is subject to meeting benefit entry criteria requirements as determined by the Scheme.
- The benefit provides cover for therapy scientifically proven for my condition, which means that not all medication for the condition will automatically be covered.
- By registering for the benefit, I agree that my condition may be subject to disease management interventions and periodic review and that this may include access to my medical records.
- Funding will only be effective once the Scheme receives an application form that is completed in full.
- Payment to the healthcare professional for the completion of this form, on submission of a claim, will be subject to the Scheme rules and where the member is a valid and active member at the service date of the claim.
- I agree to my information being used to develop registries. This means that you give permission for us to collect and record information about your condition and treatment. This data will be analysed, evaluated and used to measure clinical outcomes and to make informed funding decisions.

Membership number | **Patient name and surname**

1. MEMBER AND PATIENT INFORMATION (CONTINUED)

TO BE COMPLETED BY THE APPLICANT (CONTINUED)

PATIENT CONSENT (CONTINUED)

- To ensure that we pay your claims from the correct benefit, any claims from your healthcare providers must include the relevant ICD-10 diagnosis code(s). Please ask your doctor to also include the relevant ICD-10 diagnosis code(s) on the referral form for any pathology and/or radiology tests. This will enable the pathologists and radiologists to also include the relevant ICD-10 diagnosis code(s) on the claims they submit, thus further ensuring that we pay your claims from the correct benefit.

PATIENT DECLARATION

- I have received individual counselling and education on HIV/AIDS in a language that I understand and that I am able to make an informed decision on joining the YourLife Programme.
- I understand the benefits and conditions of the YourLife Programme.
- I understand the purpose for doing pathology tests and that these tests are required as part of the YourLife Programme.
- I understand that I will be contacted regularly by a case manager or any other healthcare worker involved in my care.
- I understand that, even though I am on the YourLife Programme, my doctor retains a responsibility for my care, irrespective of the benefits authorised.
- I understand that all personal and clinical information supplied to the YourLife Programme will be used to access and manage my HIV/ AIDS benefits.
- I understand that the YourLife Programme shall use its best endeavours to uphold the confidentiality of all information related to my HIV condition.
- I understand that calls will be recorded for internal clinical quality assurance purposes and will not be shared outside of the HIV department.
- I acknowledge that my personal details are treated as confidential, and I accept that the YourLife Programme may use these contact details to communicate with me.

CONSENT FOR PROCESSING MY PERSONAL INFORMATION

1. I hereby acknowledge that PG Group Medical Scheme has appointed Momentum Health Solutions (Pty) Ltd as the administrator of the programme and that any prescribed medical treatment shall be the sole responsibility of my medical practitioner. I understand that the information provided on this form shall be treated as confidential and will not be used or disclosed except for the purpose for which it has been obtained.
2. I hereby give my consent to the Scheme, Momentum Health Solutions and its employees to obtain my, or any of my dependants', special personal information (including general, personal, medical or clinical), whether it relates to the past or future (e.g. health and biometric) from any of my healthcare providers (e.g. pharmacist, pathologist, radiologist, treating doctor and/or specialist) to assess my medical risk, enrol me on the programme and to use such information to my benefit and to undertake managed care interventions related to my conditions.
3. I understand that this information will be used for the purposes of applying for and assessing my funding request for HIV/AIDS benefits.
4. I give permission for my healthcare provider to provide the Scheme and the administrator with my diagnosis and other relevant clinical information required to review and process my application.
5. I consent to the Scheme and the administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical) to my healthcare provider, to administer the HIV/AIDS benefits.
6. Whilst Momentum Health Solutions undertakes to take all reasonable precautions to uphold the confidentiality of information disclosed to it, I am aware that the Scheme and my healthcare provider (where necessary) shall also gain access to the same information. I shall therefore not hold Momentum Health Solutions and its employees or the Scheme and its trustees, liable for any claims by me or my dependants arising from any unauthorised disclosure of my special personal information to other parties.
7. I understand and agree that special personal information relevant to my current state of health may be disclosed to third parties for the purpose of scientific, epidemiological and/or financial analysis without disclosure of my identity.

I hereby certify that the information provided in this application is true and correct and that I voluntarily subscribe to the YourLife Programme.

Member/patient signature
(or signature of parent/ guardian if patient is under the age of 18)

Date
DD/MM/YYYY

Membership number

Patient name and surname

2. MEDICAL PRACTITIONER'S INFORMATION

TO BE COMPLETED BY THE TREATING MEDICAL PRACTITIONER

Practice number		Speciality	
Initials		Surname	
Contact numbers		Work	Fax
		Cell phone	
Postal address			
		Postal code	
Email address			

I confirm that the clinical details described in this document are accurate and correct to my knowledge. I understand that the YourLife Programme 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.

Treating medical practitioner's signature

Date DD/MM/YYYY

3. CLINICAL EXAMINATION

TO BE COMPLETED BY THE TREATING MEDICAL PRACTITIONER

Gender ☐ Male ☐ Female ☐ Other

Weight kg

Height cm

HIV category ☐ ART ☐ PEP ☐ PrEP ☐ PMTCT

Date of HIV diagnosis **(not applicable for PrEP and PEP)** DD/MM/YYYY

PEP: Date of incident DD/MM/YYYY

PMTCT: Estimated date of delivery DD/MM/YYYY

Date of HIV testing DD/MM/YYYY

Reason for testing

Test used

Has counselling been given? ☐ Yes ☐ No

If **'Yes'**, by whom

Membership number **Patient name and surname**

3. CLINICAL EXAMINATION (CONTINUED)

TO BE COMPLETED BY THE TREATING MEDICAL PRACTITIONER (CONTINUED)

Significant past medical history, including opportunistic infections and co-morbidities

	Date (DD/MM/YYYY)	Duration	Treatment received	Outcome
Operation/hospital admissions (especially if related to HIV infection)				
Medical				
Surgical				
Obstetric				
Gynaecologic				
Psychiatric				
TB				
TB meningitis				
Cryptococcal meningitis				
Concomitant drug use				
Other (please specify):				
Allergies				

Is the patient being treated for one or more of these conditions? **(please tick the appropriate block)**

- ☐ Diabetes
- ☐ Cancer
- ☐ Epilepsy
- ☐ Chronic renal failure
- ☐ Hypercholesterolaemia
- ☐ Hypertension/Cardiac failure
- ☐ Depression/Psychiatric treatment
- ☐ Other

If **'Other'**, please specify:

WHO stage

☐ 1 ☐ 2 ☐ 3 ☐ 4

Membership number **Patient name and surname**

3. CLINICAL EXAMINATION (CONTINUED)

TO BE COMPLETED BY THE TREATING MEDICAL PRACTITIONER (CONTINUED)

Please tick any symptoms below that the patient has experienced over the 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 (orolabial, genital or anorectal 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 necrotizing ulcerative stomatitis, gingivitis or periodontitis		Cytomegalovirus infection (retinitis or infection of other organs)	
Unexplained anaemia, neutropaenia, chronic thrombocytopaenia		Central nervous system toxoplasmosis	
Clinical Stage 3 – Paediatric		HIV encephalopathy	
Unexplained moderate malnutrition		Extrapulmonary cryptococcosis including meningitis	
Unexplained persistent diarrhoea (14 days or more)		Disseminated non-tuberculous mycobacteria infection	
Persistent fever > one month		Progressive multifocal leucoencephalopathy	
Persistent oral candidiasis (after first six weeks of life)		Chronic cryptosporidiosis	
Acute necrotizing ulcerative gingivitis or periodontitis		Chronic isosporiasis	
Lymph node tuberculosis		Disseminated mycosis (extrapulmonary histoplasmosis, coccidiomycosis)	
Weakness, numbness or paraesthesias in hands or feet		Recurrent septicaemia (including non-typhoidal salmonella)	

Pathology

Please attach pathology results to this application. Test results should not be older than four months.

Mandatory pathology tests	
Description	**Tariff code**
ELISA test	3932
Viral load	4429*
CD4 count	3816*
CD4% (child <12 years)	3816*
AST	4130*
ALT	4131*
Full blood count (FBC)	3755*
Urea and electrolytes	4171
Hepatitis B antigen	4531

*ART and PMTCT only

Medication and treatment

Previous and current antiretroviral therapy (ART) and prophylaxis; also indicate current chronic medication

Medication	Dose	Date commenced (DD/MM/YYYY)	Date stopped (DD/MM/YYYY)	Reason stopped/side effects

Membership number _____ **Patient name and surname** _____

3. CLINICAL EXAMINATION (CONTINUED)

TO BE COMPLETED BY THE TREATING MEDICAL PRACTITIONER (CONTINUED)

Medication and treatment (continued)

Previous and current antiretroviral therapy (ART) and prophylaxis; also indicate current chronic medication

Medication	Dose	Date commenced (DD/MM/YYYY)	Date stopped (DD/MM/YYYY)	Reason stopped/side effects

Keep current ARTs? ☐ Yes ☐ No

If **'No'**, please indicate new ARTs below.

New treatment requested (including ART prophylaxis for baby, where applicable)

Medication	Dose

Medication	Dose

Membership number _____ **Patient name and surname** _____