BMW Employees Medical Aid Society

Administered by Discovery Health

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 2022, 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 notf-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@discovery.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.

1. Patient details

Title | Surname

First name/s

Date of birth (D D M M Y Y Y Y) | ID or passport number

Gender M F

Race African | Coloured | Indian / Asian | White | Other

This information is required by the Council for Medical Scheme for statistical purposes. You are not compelled to provide this information.

do not want disclose | Membership number

Telephone (H) | (W)

Cellphone (C) | (F)

Email address

The outcome of this application must be sent to me by Email Fax

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.avgms.co.za

Patient's name and surname

Membership Number

2. Main member details (Please complete this section if the patient is a minor)

Title | Surname

First name/s (as per identity document)

Membership number | Date of birth (D D M M Y Y Y Y)

BEMHPA001

Please note that this form expires on 31/03/2023. The latest version of the application form is available on www.bemas.co.za. Alternatively members can phone 0860 002 107 and health professionals can phone 0860 44 55 66.

ID number Gender M F

Race African Coloured Indian / Asian White Other

This information is required by the Council for Medical Scheme for statistical purposes. You are not compelled to provide this information.

Do not want to disclose

Telephone (H)

Work

Cellphone

Fax

Email address

Patient's signature

Date D D M M Y Y Y Y

If patient is a minor,main member must sign

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 D D M M Y Y Y Y

Height (cm) 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 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: 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 (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 a generic medicine?	
				Years	Months	Yes	No
HIV							
Opportunistic infections							

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

Name and surname

BHF Practice Number

Telephone

Fax (F)

Cellphone (C)

Email

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.

Signature of doctor

Date D D M M Y Y Y Y