Contact us
Tel: 0800 BANKMED (0800 226 5633) • Private Bag X2, Rivonia 2128 • www.bankmed.co.za

Request for pre-exposure prophylaxis (PrEP)

Who we are

Bankmed (referred to as 'the Scheme'), registration number 1279, 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) which takes care of the administration of your membership for the Scheme.

The preferred provider for GP consultations is the Premier Plus HIV GP Network.

How to complete this form

Step 1: Ensure the form is completed in full and signed by a Healthcare Professional
Step 2: Please return the completed form to us by e-mail to **HIV@bankmed.co.za**

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 PREP 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 Professional and to relevant third parties, to administer the PREP Benefit as well as undertake managed care interventions related to the benefit.

1. Patient details (to be completed by the patient or the member)

Title | Initial(s)

First name(s)

Surname

Membership number

ID or passport number

Telephone (H) | Telephone (W)

Cellphone

E-mail

Relationship to Principal Member

2. Principal Member details

Membership number

ID or passport number

Member's surname

Member's name

3. Clinical data (to be completed by Healthcare Professional)

Expected treatment start date: D D M M Y Y Y Y

Expected duration of treatment:

Clinical reason for requesting PREP:

Special investigation results (please provide copies of the reports):

	Test done?		If yes, specify results	Test date
Baseline HIV test*	Yes	No		D D M M Y Y Y Y
Serum Creatinine/eGFR	Yes	No		D D M M Y Y Y Y

*Require a negative ELISA result < 1 month old before we will approve treatment.

4. Medication (to be completed by Healthcare Professional)

Medication name, strength and dosage	Number of repeats	How long has the patient used this medication?		May the patient use a generic medication?		
		Years	Months	Yes	No	Reason

We will approve funding for generic medication where available, unless you have indicated otherwise
Kindly specify any other medication that the patient uses regularly

5. Healthcare Professional's details (to be completed by the Healthcare Professional)

Name

BHF practice number

Telephone

Cellphone

E-mail

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 Bankmed.

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@bankmed.co.za**.

Healthcare Professional's signature

Date D D M M Y Y Y Y