

**Contact details**

Tel: 0800 001 615 • PO Box 652509, Benmore 2010 • [www.engenmed.co.za](http://www.engenmed.co.za)

## Request for pre-exposure prophylaxis (PREP)

This application form is to register for pre-exposure prophylaxis and to apply for antiretroviral prophylaxis medicine. Cover for antiretroviral prophylaxis medicine is available subject to the Fund Rules and the terms and conditions of the benefit.

### Who we are

Engen Medical Benefit Fund, registration number 1572, is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, is a separate company, an authorised financial services provider and is responsible for the administration of your membership on behalf of the Fund.

### How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. Please make sure the form is completed in full and signed by a healthcare professional.
3. Once complete, please email it to [HIV@engenmed.co.za](mailto:HIV@engenmed.co.za).

### Consent for processing my personal information

I give the Fund 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 Fund 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 PREP Benefit as well as undertake managed care interventions related to the benefit.

### 1. Patient details

Title	<input type="text"/>	Initial(s)	<input type="text"/>
First name(s)	<input type="text"/>		
Surname	<input type="text"/>		
Membership number	<input type="text"/>	<input type="text"/>	<input type="text"/>
ID or passport number	<input type="text"/>	<input type="text"/>	<input type="text"/>
Telephone (H)	<input type="text"/>	Telephone (W)	<input type="text"/>
Cellphone	<input type="text"/>	<input type="text"/>	<input type="text"/>
E-mail	<input type="text"/>		
Relationship to main member	<input type="text"/>		

Please ensure your contact details are always up to date as we rely on this information to send you important information. You may update your details on [www.engenmed.co.za](http://www.engenmed.co.za).

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

Membership number	<input type="text"/>
ID or passport number	<input type="text"/>
Member's name	<input type="text"/>
Member's surname	<input type="text"/>
E-mail	<input type="text"/>
Patient's signature	<input type="text"/>

Date

**If patient is a minor, main member must sign**

### 3. Clinical data (to be completed by doctor)

Expected treatment start date: 

D	D	M	M	Y	Y	Y	Y
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 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 <input type="checkbox"/> No <input type="checkbox"/>	<input style="width: 200px;" type="text"/>	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y				
Serum Creatinine/eGFR	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input style="width: 200px;" type="text"/>	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y				

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

### 4. Medicine (to be completed by doctor)

Medicine	Dosage	Duration of treatment

Please specify any other medicine that the patient uses regularly


### 5. Treating Doctor's details (to be completed by the doctor)

Name

BHF practice number 

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 Telephone 

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Cellphone 

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E-mail address

I acknowledge that:

1. The approval of this treatment is subject to the HIV status of the patient, and that
2. I have received the patient's consent to disclose their HIV status and any other related information to Engen Medical Benefit Fund and Discovery Health (Pty) Ltd.

#### 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@engenmed.co.za](mailto:HIV@engenmed.co.za).

Signature of doctor

Date 

D	D	M	M	Y	Y	Y	Y
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Please only sign if information is true, complete and correct.