



STRICTLY CONFIDENTIAL

bestMed

personally yours

LifeSense Disease Management
ADULT APPLICATION

Please complete this form and return it to LifeSense.

Email: results@lifesense.co.za

Fax: 0860 80 49 60

Please note: All fields marked with * are compulsory fields: If not completed your Application will not be processed.

MAIN MEMBER DETAILS	
Surname	
Name(s)	
ID Number	
Sex (Male / Female)	

APPLICANT MEDICAL AID DETAILS			
Medical Scheme		Medical Scheme Number	
Scheme Option		Dependant Code	

APPLICANT DETAILS			
Surname			
Name(s)			
ID Number		Male	Female
Date of Birth	DD/MM/YYYY		
Marital Status	Single	Married	Divorced
	Widow(er)	Common Law	

APPLICANT CONTACT DETAILS			
Physical Address			
Postal Code			
Province			
Postal Address			
Postal Code			
Province			
Telephone Number (H)	Include Dialling Code	Telephone Number (W)	Include Dialling Code
Cell phone Number		SMS Number	
Preferred Follow Up	SMS E-Mail	E-mail Address	

NEXT OF KIN DETAILS	
Name & Surname:	
Relationship:	
Contact Number:	
Next of kin aware of Status	YES NO

EMPLOYER DETAILS	
Employer Name	
Job Description	
Province	
Shift	Day Shift Night Shift

*PHARMACY SELECTION based on choice please complete table 1 or 2 below Please select from the table below the Pharmacy of your choice from whom you wish to receive your medicine.			
Clicks Direct Medicine Courier Pharmacy		Clicks Retail Pharmacies	
Dis-Chem Direct (Previously Optipharm Courier Pharmacy)		Dis-Chem Retail Pharmacies	
Medipost Courier Pharmacy			

1: RETAIL PHARMACY DETAILS
Required if your choice is a Retail Pharmacy: You will be responsible for collection of medicine

Clicks Retail Pharmacies	Name of Clicks (e.g. Clicks East Rand Mall)		
	Province		Postal Code
Dis-Chem Retail Pharmacies	Name of Dischem (e.g. Dis-Chem East Rand Mall)		
	Province		Postal Code

2: MEDICINE DELIVERY ADDRESS
Required for Courier Pharmacy purposes: Courier pharmacy will deliver to the address as per below

Please tick your preferred delivery	Doctor		Home		Work		Post Office	
Delivery address								
Postal Code		Province						

MEDICAL INFORMATION: THIS SECTION HAS TO BE COMPLETED BY THE TREATING DOCTOR. ALL FIELDS MARKED WITH AN * HAVE TO BE COMPLETED. IF NOT COMPLETED, THE APPLICATION WILL NOT BE PROCESSED.

*ICD-10 Code		*Date First Hiv Positive Test	
Height		Weight	BP
*Has the patient had / have any AIDS defining illnesses?	If YES: Please state below		
*Medicine Allergies	If YES: Please state below		
*Other Chronic Illnesses	If YES: Please state below		
	Chronic Illness Medicines: Please state below		
Patients Partner HIV Status	Positive Negative Unknown	Is partner on ARV's ?	Yes No
Is the Patient's Partner Aware of the Patients Status?	Yes No		

*TREATMENT DETAILS	
*Previous treatment	If YES: Please state which drugs, please include Start & End Date:
*Current treatment	Please include start date of treatment:
*If Patient is Treatment Naïve, please list suggested treatment	
*Generic equivalent substitutions	Yes No
<p>*PLEASE ATTACH ORIGINAL SCRIPT FOR ALL ART AND PROPHYLACTIC MEDICINES Should the applicant refuse a generic equivalent, then he/she may be liable for a co-payment as per the schemes rules</p>	

BLOOD TESTS			
Date		Laboratory	
Requisition No.			
SEROLOGY TEST	RESULT	SEROLOGY TEST	RESULT
CD4 COUNT		VIRAL LOAD	
FBC		CREATININE	
PLATELETS		UREA	
ALT		AST	
PLEASE NOTE: 1. ONLY THE ABOVE TESTS ARE COVERED UNDER THE B24 CHRONIC BENEFIT 2. GENOTYPING REQUIRES PRIOR AUTHORISATION			
PREGNANCY STATUS: (Female patients)			
*Pregnancy test	Positive Negative	LMP	EDD
TB STATUS			
TB Screening	Yes No	Positive	Negative
TB Medicine			

Doctor's details: proof of identification must be signed by the examiner.

I, **the Examiner** acknowledge that I have counselled the applicant on the usage of the medicine and should the applicant default in taking the medicine, it could lead to multi-drug resistant virus. Should the applicant refuse a generic equivalent, then he/she may be liable for a co-payment as per the schemes rules. I declare that I have taken due and proper care to verify the true identity of the applicant as stated above & have witnessed his/her signature.

DOCTORS PRACTICE DETAILS			
Surname		Name (Initials)	
Practice no.		MP Number	
Practice address			
Postal code		Province	
Tel.		Fax	
Cell		E-mail	
Preferred means of communication	Fax: E-mail:	Are you willing to accept Medicine deliveries to your rooms?	Yes: No:

Doctor signature	_____	Date	____/____/____
------------------	-------	------	----------------

***THIS SECTION MUST BE READ AND UNDERSTOOD BY THE SIGNED APPLICANT**

Your participation in this programme is one of the most important ways to keep you well. For registration you will be required to answer medical questions, undergo a physical examination and have blood tests taken every 24 weeks and only on request of the case manager. If you have any queries please do not hesitate to ask your doctor doing this examination about any of these tests.

I, **the Applicant** acknowledge that the examiner has explained the usage of the Medicine to me, if applicable.

I, **the Applicant** acknowledge that I am HIV positive and consent to the use of the appropriate HIV/AIDS Medicine prescribed by the treating service provider, if applicable. I the applicant acknowledge that I will be responsible for any co-payment that may be imposed as per medical scheme rules.

I, **the Applicant** understand that in order for the payment of services to the doctor or any other service provider, the medical scheme will need to know my identity. I hereby consent to the above procedures. I agree that the medical information relevant to my HIV infection may be used for purposes of scientific, epidemiological and/or financial analysis without disclosure of my name and that LifeSense may send medical information to the treating doctor and medical scheme if required.

LifeSense and your medical scheme adhere to the confidentiality as laid out by the Health Professional Council of South Africa (HPCSA). All personal information collected will be stored in accordance with Protection of Personal Information (POPI) ACT.

I, **the Applicant** also acknowledge receipt of the Bestmed Introduction letter and understand the contents therein.

Applicant ID number		Place	
Applicant signature	_____	Date	____/____/____

Dear member

AN INTRODUCTION TO THE BESTMED HIV/AIDS DISEASE MANAGEMENT PROGRAMME



Bestmed has an effective HIV/AIDS Disease Management Programme (DMP) for members living with HIV/AIDS. By registering for the HIV/AIDS DMP, you'll receive the support you need to maintain a healthy and productive life.

We've contracted with LifeSense, a managed care organisation, to provide a consolidated programme. LifeSense is responsible for managing the programme's administration. A skilled LifeSense case manager will contact you to provide the necessary programme information and assist you with any queries related to either the programme or the disease.

LIFESENSE — CONTACT DETAILS	
Tel	086 050 6080
Fax	086 080 4960
Email	enquiry@lifesense.co.za

Programme information

- Once registered on the programme, you will be monitored for compliance on a continuous basis.
- You may only make use of the Designated Service Providers (DSPs) selected by Bestmed. These include medical practitioners, pharmacy networks and hospitals.
- Should the unfortunate situation arise where you involuntarily have to utilise the healthcare services of a non-DSP hospital, no co-payment will be applicable. To gain clarity on which instances will be considered as involuntary use of a non-DSP, please refer to Bestmed's rules on our website: <http://www.bestmed.co.za/content/scheme-rules>.
- Should you choose to voluntary make use of a hospital outside of Bestmed's DSP network (non-DSP), you will be liable for the difference of any amount exceeding the contracted DSP rates.

IMPORTANT INFORMATION

To manage your HIV/AIDS successfully, blood tests are required every 6 months.
Please ensure LifeSense receives your blood test results timeously.

Your HIV/AIDS medicine should be reviewed by your treating doctor every 6 months.
Failure to do so, may result in you not receiving your monthly medicine on time.

The table below indicates which blood tests are required at specific intervals on the programme. If you are unsure of which tests you require or are covered for, please contact LifeSense prior to going for your blood tests. 086 050 6080

PATHOLOGY PROTOCOL FOR HIV & AIDS MANAGEMENT

Six monthly blood tests and tariff codes	Yearly blood tests and tariff codes
HIV Monitoring tests <ul style="list-style-type: none"> ▪ CD4 Count (3816) ▪ Viral Load (4429) 	<ul style="list-style-type: none"> ▪ Testing for Baby to HIV mothers (3974) ▪ TB Screening (3916)
Other monitoring tests <ul style="list-style-type: none"> ▪ Full Blood Count (3755) ▪ Kidney Function (4032; 4151) ▪ Total Cholesterol (4027) ▪ Glucose Test (4057) ▪ Liver Function (4131; 4130; 4134) ▪ Bilirubin (4009; 4010) 	
Motivation will be required for a HIV resistance test. (Genotyping)	

For additional information on the benefits available for members on the HIV/AIDS programme, please visit the LifeSense website: www.lifesensedm.co.za or contact LifeSense by phoning: **086 050 6080**.

Pharmacies dispensing anti-retroviral therapy (ART)

Bestmed has an extended pharmacy network. Members who require ART (Anti-Retroviral Treatment) can acquire it from Dis-Chem Direct (Previously Optipharm Courier Pharmacy), Dis-Chem Retail Pharmacies, Clicks Courier Pharmacy, Clicks Retail Pharmacies or Medipost Courier Pharmacy. These pharmacies are the designated service providers (DSPs) for the dispensing of ART to Bestmed members.

PHARMACY CONTACT DETAILS

Clicks Direct Medicine (Courier Pharmacy)		Clicks Retail Pharmacies	
Contact centre	086 144 4405	Contact centre	086 073 7328
Fax	086 144 4414	Fax	021 460 6752
Email	DMHIVQE@dirmed.co.za	Email	repeat@clicksgroup.co.za
Emergency contact	010 210 3364 or 010 210 3330	Website	https://clicks.co.za/pharmacy/ClinicServicesPharmacylocator

Dis-Chem Direct (Previously Optipharm Courier Pharmacy)		Dis-Chem Retail Pharmacies	
Contact centre	011 589 2788	Contact centre	011 589 2604
Fax	086 641 8311	Website	www.dischem.co.za/storelocator
Email	bestmed@dischem.co.za	Email	bestmed@dischem.co.za
Emergency contact	083 564 9978		
Medipost Courier Pharmacy			
Tel	012 426 4000		
Fax	086 688 9867		
Chronic medicine (after hours)	087 098 0400		
Email	life@medipost.co.za		

Should you have any additional queries, please call our national contact centre on **+27 (0)86 000 2378** or visit our website www.bestmed.co.za. Alternatively, members residing outside of South Africa, can contact Bestmed, by sending an email to service@bestmed.co.za or phone **+27 (0)12 472 6000**.

Kind regards

Bestmed Disease Management

mhc@bestmed.co.za