Request for pre-exposure prophylaxis (PREP) 2025

MALCOR MEDICAL AID SCHEME
Administered by Discovery Health

Contact details
Tel: 0860 100 698 • PO Box 8012, Greenstone 1616 • www.malcormedicalaid.co.za

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 Scheme Rules and the terms and conditions of the benefit.

This form is valid for 2025.

Who we are

The Malcor Medical Aid Scheme (referred to as 'the Scheme'), registration number 1547, 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). We take care of the administration of your membership for the Scheme.

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_Diseasemanagement@malcormedicalaid.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 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 | Initials

Surname

First name(s)

Membership number

ID or passport number | Telephone (H)

Telephone (W) | Cellphone

Email address

Relationship to main member

Please ensure your contact details are always up to date as we rely on this information to keep you updated. You may update your details on www.malcormedicalaid.co.za.

2. Main member details

Membership number

ID or passport number

Member's name

Member's surname

Email address

Patient's signature | Date Y Y Y Y M M D D

(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

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. Medicine (to be completed by doctor)

Medicine	Dosage	Duration of treatment

Please specify any other medicine that the patient uses regularly

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

Name

BHF Practice number Speciality

Telephone Cellphone

Email

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 Malcor Medical Aid Scheme.

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_Diseasemanagement@malcormedicalaid.co.za.**

Signature of doctor

Date D D M M Y Y Y Y