STRICTLY CONFIDENTIAL

LifeSense Disease Management
ADULT APPLICATION:
Bestmed Medical Scheme
Members

Please complete this form and return it to LifeSense.
Email: results@lifesensedm.com
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	
Gender (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 Dialing Code	Telephone Number (W)	Include Dialing 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 Dis-Chem (e.g. Dis-Chem East Rand Mall) Province Postal

2: **MEDICINE DELIVERY ADDRESS** Required for Courier Pharmacy purposes: Courier pharmacy will deliver to the address as per below								
Please tick your preferred	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 ARVs?	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 and End Date:
*Current treatment	Please include start date of treatment:
*If Patient is Treatment Naïve, please list suggested treatment	
*Generic equivalent	Yes No
*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 Scheme's rules	

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 Scheme's rules. I declare that I have taken due and proper care to verify the 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	_____/_____/_____

THE PROTECTION OF PERSONAL INFORMATION ACT 4 OF 2013 (POPI) NOTICE AND CONSENT FORM

1. The Protection of Personal Information Act (POPI) aims to give effect to the constitutional right to privacy by balancing the right to privacy against that of access to information. POPI requires that personal information pertaining to individuals be processed lawfully and in a reasonable manner that does not infringe on the right to privacy.
2. LifeSense understands that your personal information is important to you and that you may be apprehensive about disclosing such information. Your privacy is of the utmost importance to LifeSense and LifeSense is committed to safeguarding and processing your personal information in a secure and lawful manner.
3. The personal information that LifeSense **will process**; your first and last name, your title, date of birth, contact details (work and home), medical aid details and history, identification number, passport number, gender, medical information, occupation, email address, residential and postal address.
   3.1. POPI provides that the term **"processing"** covers any operation or activity, whether or not by automatic means, concerning personal information. Such activity may include, but is not limited to, collection, receipt, recording, organisation, storage, collation, retrieval, alteration, updating, distribution, dissemination by means of transmission, erasure or destruction of personal information.
4. LifeSense would also like to make sure that you understand how and for what purpose we shall process your personal information. If you for any reason think that your personal information is not being processed in a correct manner, or that your personal information is being used for a purpose other than that for which it was originally intended, you can contact our offices. You can request access to the information we hold about you at any time and can also request that we update or correct our information should you believe that such personal information is outdated.
5. LifeSense shall collect, hold, process, use and disclose your personal information in order to provide you with access to services and products which LifeSense provide in the ordinary course of its business. We will only process your personal information for a purpose you would reasonably expect, including but not limited to:
   5.1. registering you for your chronic medicine benefits with your medical scheme. LifeSense shall receive information from and share information with your treating doctor, medical scheme and dispensing pharmacy;
   5.2. confirming and verifying your identity as per the information received on your application form;
   5.3. confirming, verifying and updating your details on your LifeSense profile;
   5.4. corresponding with your appointed treating doctor in respect of your HIV status and medication;
   5.5. providing you and your treating doctor with personalised communication;
   5.6. providing you with advice, medication and services which suit your individual HIV healthcare needs and requirements;
   5.7. corresponding with pathology laboratories in respect of your blood test results;
   5.8. managing your HIV treatment in collaboration and consultation with your treating doctor, thereby allowing pharmacies to dispense the correct medication;
   5.9. administering and updating your profile on the LifeSense system in terms of your personal details, contact details, treating doctor details, medication and updated blood test results;
   5.10. record-keeping purposes;
   5.11. complying with any legal and regulatory requirements; and
   5.12. any other purpose for which you have provided consent.
6. Whenever we are required to share your personal information, LifeSense shall take all precautions to ensure that your information is transferred in a secure manner and that the third-party service provider will treat your information with the same level of protection as required by LifeSense.

- I hereby provide authorisation and my consent to LifeSense to process and disclose my personal information provided for the purpose stated hereinabove, which purpose has been fully explained to me.
- I understand that withholding of or failure to disclose personal information will result in LifeSense's records being incomplete and may negate any performance on the part of LifeSense.
- Where I shared personal information of individuals other than myself with LifeSense, I hereby provide consent on their behalf to the processing and disclosure of their personal information in accordance with this consent provided and I warrant that I am authorised to give this consent on their behalf.
- To this end, I indemnify and hold LifeSense harmless in respect of any claims by any other person, on whose behalf I have consented, against LifeSense should they claim that I was not so authorised.
- I understand that in terms of POPI and other laws of the country, there are instances where my express consent is not necessary in order to permit the processing of personal information, which may relate to litigation or where personal information is publicly available. I will not hold LifeSense responsible for any improper or unauthorised use of personal information that is beyond LifeSense's reasonable control.

Full name	
Identification number	
Signature	
Date	