YourLife PROGRAMME

Pick n Pay Medical scheme

APPLICATION FORM
HIV APPEALS AND MOTIVATION

PLEASE USE BLOCK LETTERS FOR ALL SECTIONS

HIV APPEALS AND MOTIVATION PROCESS FOR HEALTHCARE PROVIDERS

Purpose
The purpose of the HIV appeals and motivation process is to resolve clinical-related queries.

Steps to follow
1. You are required to complete this HIV appeals and motivation form, documenting all details and reasons for the appeal.
2. Criteria that meet eligibility for an appeal will include:
   - a particular case that was referred to and declined by a medical advisor
   - additional or alternative treatment required that is not prescribed within our HIV treatment guidelines
   - additional benefits required that are not prescribed within our HIV treatment guidelines
   - cases where a medication or a procedure has previously been approved and that has now been rejected
   - motivation for genotype testing.
3. Send the completed appeal and motivation to the YourLife Programme.
4. The clinical manager will review the appeal based on feedback from the Scheme's case and operations managers.
5. The case may be referred to a medical advisor if deemed necessary.
6. Final consensus on the case will be reached after review by the YourLife Programme's executive manager.
7. The case may take up to five working days to be resolved.
8. Thereafter you will have five working days to respond to the decision.

MAIN MEMBER DETAILS

Membership number			
Title		Initials	
Name and surname			

PATIENT DETAILS

Name and surname				Dependant code	
Age				Gender ☐ Male ☐ Female	
Date of birth		DD/MM/YYYY		ID number	
Date of registration		DD/MM/YYYY		Province	
Cell phone number					
Email address					

PATIENT'S TREATMENT/MEDICAL HISTORY

HIV category ☐ On ART ☐ Not on ART ☐ PEP ☐ PMTCT

If the patient is pregnant, please provide the estimated delivery date _____ DD/MM/YYYY

Membership number _____ **Patient name and surname** _____

PATIENT'S TREATMENT/MEDICAL HISTORY (CONTINUED)

Tuberculosis (TB) ☐ Yes ☐ No Previous TB? ☐ Yes ☐ No

TB treatment Start date DD/MM/YYYY

End date DD/MM/YYYY

ARV MEDICATION	REGIMEN	DATE COMMENCED (DD/MM/YYYY)	DURATION ON ART	DATE STOPPED (DD/MM/YYYY)

Reason for cessation:

Side effects:

Adherence:

PATHOLOGY							
DATE (DD/MM/YYYY)	CD4	Viral load	Hb	Platelets	ALT	AST	Creatinine CL

Membership number **Patient name and surname**

APPEAL/MOTIVATION

HEALTHCARE PROVIDER DETAILS AND CONSENT

Surname			
Initials			
Practice number		Provider discipline	
Physical address			
		Postal code	
Telephone numbers		Work	Fax
		Cell phone	
Email address			

I confirm that the clinical details described in this document are accurate and correct to my knowledge. I understand that the YourLife Programme treatment protocols are guidelines only and that the ultimate responsibility regarding antiretroviral therapy and general management of my patient's HIV condition will reside with me. The reimbursement of therapy and related costs by the Scheme will be in accordance with the guidelines as well as the benefit available to the above patient from time to time.

Doctor's signature

Date

DD/MM/YYYY

Membership number

Patient name and surname

04/2023