



HIV APPEALS AND MOTIVATION PROCESS FOR 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 the HIV appeals and motivation form, documenting all details and reasons for the appeal.
2. Criteria that may meet eligibility for an appeal includes:
 - a 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 HIV **YourLife** Programme.
4. The clinical manager will review the appeal based on feedback from the Fund'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 HIV **YourLife** Programmes 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.

HIV **YourLife** Programme

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HIV APPEALS AND MOTIVATION FORM



Name of patient					Medical fund/employer group					Membership no.		Dependant code		Age		Gender		Date of registration				Province																																																				
Category					Pregnant? Estimated date of delivery					Tuberculosis (TB)					Date commenced		Date stopped		M		F		D		M		Y		Y		YES		NO		PREVIOUS TB																																							
																																							on ART		PEP		MTCT		D		M		Y		Y		Y		Y		D		M		Y		Y		D		M		Y		Y			
ARV medication					Regimen					Date commenced					Duration on ART					Adherence																																																						
Reason for cessation																									Side effect(s)																									Adherence																								

PATHOLOGY																											
Date			CD4	Viral load	Hb	Platelets	ALT	AST	Creatinine	CL																	
D	D	M	Y	Y	Y																						
D	D	M	Y	Y	Y																						
D	D	M	Y	Y	Y																						

APPEAL/MOTIVATION:

HEALTHCARE PROVIDER DETAILS														
Name				Practice no.				Contact no.				Date		