Broker House: Aon South Africa (Pty) Ltd
Tel No: 0860 835 272
Broker Code: 8503

MEDISCOR

PO BOX 8796
Centurion
0046

CONTROL NUMBER

APPLICATION FOR CHRONIC MEDICINE BENEFITS

ONLY FULLY COMPLETED FORMS RETURNED BY POST OR FAX WILL BE PROCESSED AND AUTHORISED

CONTACT TEL NO: 012-674 8000 / 0800-119553 FAX NO: 012- 674 8032

SECTION 1: PRINCIPAL MEMBER DETAILS

Member details only, not patient details
(To be completed by member or patient)

Surname:

First names:

Title:

Postal address:

Postal Code:

Telephone number: Home: ( )

Work: ( )

Cell: ( )

E-mail address:

Medical scheme:

Membership number:

SECTION 2: PATIENT CONSENT (To be completed by patient)

I hereby give permission for my doctor to state the diagnosis of my condition on my form and I understand that this information will remain confidential.

Patient signature: Date:

SECTION 3: PHARMACY DETAILS (To be completed by member or patient)

Pharmacy name:

BHF practice number:

Telephone number: ( )

Fax number: ( )

SECTION 4:	DOCTOR'S PRACTICE DETAILS	(Can be completed by member or patient, receptionist or doctor)

Doctor's surname and initials: **Qualifications:**

BHF practice no. Tel. No ( ) Fax no. ( )

IF TREATMENT WAS INITIATED BY A SPECIALIST, PLEASE SPECIFY: NAME

Speciality:

SECTION 5:	PATIENT DETAILS	(Please complete as per membership card)

Medical scheme: Principal member no:

Patient surname: Patient first name:

Dependant code: Birth date: Sex:

SECTION 6:	PATIENT MEDICATION DETAILS	(To be completed by the attending medical practitioner)

Diagnosis / Chronic conditions	Medicine and strength (Generic where appropriate)	Dosage	Quantity	Number of repeats (months)

SECTION 7:	PATIENT'S DISEASE PROFILE (Other Conditions Not Mentioned Above)

SECTION 8:	PATIENT'S ALLERGY PROFILE

SECTION 9:	REASONS FOR CHANGING OR ADDING MEDICATION	(To be completed by doctor)

DOCTOR'S SIGNATURE **DATE:**

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