



Pharmacy Direct Practice No. 0126225
Postal Address: P.O. Box 7344
CENTURION
0046
Street Address: No. 23 Kwartsiet Crescent
Zwartkop Ext. 5
CENTURION

Please complete this form and fax it to **0866 114 000/1/2**
Please dial **0860 027 800** if you need to speak to a customer service agent
Assistance is also available on www.pharmacydirect.co.za or care@pharmacydirect.co.za

Information of Main Member

Initials 1st Name Surname
ID No. Medical Aid
Medical Aid No. Option Pensioner Y N
Tel Work - Home
Cell. - E-mail

Information of Patient 1

Initials 1st Name
Surname
Tel Work. -
Cell. -
ID No.
Gender M F Doctor

Information of Patient 2

Initials 1st Name
Surname
Tel Work. -
Cell. -
ID No.
Gender M F Doctor

Address Detail

Home/ Physical Address
Building Street & No.
Suburb Town/ City Postal Code
Postal Address (If different to home)
Line 1 Line 2
Suburb Town/ City Postal Code
Work Address
Building Street & No.
Suburb Town/ City Postal Code
Please deliver to my - Work Postal Address Home (Only if someone can receive parcels)

Service Required

Please deliver my medication to the indicated address - Automatically every 28 days By request
Do you agree to generic substitution? Y N Do you agree to therapeutic substitution? Y N
My first medication is expected on / / 20 (Subject to Medical Aid approval)
I need my first delivery of medication on / / 20

IMPORTANT: Please note a valid, repeat prescription will be required every 6 months as per legislation
The applicant acknowledges that he/she is responsible for payment of any levies, co-payments or rejections that the medical scheme may impose, and to inform Pharmacy Direct of any changes to his/her medical aid detail.

Signature: Main Member: _____ Date: _____