PATIENT INFORMATION AND PAYMENT DETAILS

Medipost Pharmacy

MAIN MEMBER DETAILS

Surname		Telephone (H)	C O D E
Initials		Telephone (W)	C O D E
Name		Cell phone	
Medical Scheme		ID number	
Plan Option		Date of Birth	Y Y Y Y M M D D
Medical Aid No.		E-mail	
Alternative contact number			

ADDRESS DETAILS

Postal address		
	Code	
Residential address		
	Code	
Work address		
	Code	

DELIVERY DETAILS

	Code	

PATIENT DETAILS

Each patient receiving medication must be listed in this section

Dependant Code	1 Name	Date of Birth Y Y Y Y M M D D	Sex M/F	
(As per membership card)	2			
	3			

Preferred date of first delivery _____

ORDERING METHOD

Automatically sent every 28 days ☐ Patient to place order ☐

Do you and your doctor agree to the use of generic medicine for your prescription?	No		Yes	

In the event that my Medical Aid fails to pay for the medication supplied to me and my dependants by MEDIPOST, I confirm and acknowledge that I, as principal member, will remain responsible for the payment to MEDIPOST who are entitled to seek payment from me for any amounts not paid by the Medical Aid on my behalf.

Signature: Main Member _____ Date _____

Return completed form to:
MEDIPOST, PO BOX 40101, ARCADIA, 0007

PAYMENT DETAILS
In the event that you want to receive medication not paid / partly paid by your medical aid

Account holder					Bank			
Account type		Cheque	Savings	Transmission	Credit Card		CCV number (last 3 digits on back of card)	
Account no. or Credit Card no.							Branch code	
Day of month for ACB Transaction (please tick)		15th last day of the month						
Signature: Account holder						Date		