HERITAGE HEALTH
We care about your health

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## A. Chronic Medication Registration Request

| | |
|---|---|
| Principal Member Details Below | Membership Number |
| Surname | |
| First Names | |
| Personal Postal Address | |
| Tel Code and Number | |
| Fax Code and Number | |
| Cell Phone Number | |
| Email Address | |
| Date of Birth | D D M M Y Y Y Y |
| Gender | Male Female |
| ID/Passport Number | |

## B. Particulars of member requesting registration of chronic medication

| | |
|---|---|
| Full Names of Patient | |
| Tel Code and Number | |
| Fax Code and Number | |
| Cell Phone Number | |
| Email Address | |
| Date of Birth | D D M M Y Y Y Y |

I AUTHROISE THE MEDICAL AID FUND TO OBTAIN MORE CLINICAL INFORMATION ON MY/OUR BEHALF

…… ……

SIGNATURE PRINCIPAL MEMBER/PATIENT DATE

## C. Particulars of Attending Medical Practitioner

*Information on this page to be provided by the doctor.*

| | |
|---|---|
| Name of Doctor | |
| Name of Practice | |
| Practice Number | |
| Tel Code and Number | |
| Fax Code and Number | |
| Mobile Number | |
| Email Address | |

## D. Chronic medication to be registered *Copy of a valid prescription must be submitted*

| | |
|---|---|
| Detailed Diagnosis | |
| Date of Diagnosis | |
| Date of commencement | |
| Trade/Generic name | |
| Medical History | |
| Weight | Height Blood Pressure |
| Any allergies | |

…….. ……

SIGNATURE OF DOCTOR/PRACTICE DATE

## E. Authorisation details *(office use)*

Date received: ……

Date processed: ……

Approved: ……

Declined and reason: ……

Inform patient: ……

Employee name: …… Signature: …… Date: ……