Chronic Appliance Benefit Application Form

TO BE COMPLETED BY APPLICANT

MEMBER DETAILS:

PLAN

MEMBERSHIP NUMBER

SURNAME

TITLE INITIALS ID NUMBER

E-MAIL ADDRESS

PATIENT DETAILS:

SURNAME

FIRST NAME TITLE

ID NUMBER

ADDRESS

E-MAIL ADDRESS

TELEPHONE (W) (H) CELL

I authorise my medical practitioner to furnish and/or disclose to Bankmed any fact relating to this application as well as any additional information that may be required from time to time. (Remember that your medical practitioner bears the responsibility of prescribing the appliance for you, irrespective of the benefit authorised.)

MEMBER'S SIGNATURE ______________________ DATE D D M M C C Y Y

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

DOCTOR DETAILS:

SURNAME INITIALS

PRACTICE NUMBER SPECIALITY

TELEPHONE FAX CELL

POSTAL ADDRESS CODE

E-MAIL ADDRESS

DOCTOR'S PRACTICE NUMBER ______________ SPECIALITY ______________

PATIENT DETAILS:

MEMBERSHIP NUMBER OF MAIN MEMBER ______________

PATIENT'S NAME AND SURNAME ______________ DATE OF BIRTH D D M M C C Y Y

The following appliances qualify for consideration for insured benefits subject to clinical motivation by the medical practitioner who prescribes the appliance. A detailed supplier quotation must be attached to this application form. Approval of certain items may also be subject to registration with the Care-Giver Programme.

Tick the box applicable to indicate the item(s) being prescribed.

01	Colostomy products	02	Be-sure products	03	Catheter bags and catheters
04	Suction catheter and machine	05	Glucometer	06	Nebuliser
07	Deep-vein thrombosis stockings	08	Crutches	09	Walking frame
10	Wheelchairs (to be specified)	11	Hire of C.P.A.P. apparatus	12	Oxygen
13	Braces/Callipers/Surgical boots (in combination)	14	Sleep apnoea monitor (for infants only)	15	Splints
16	Lumbar sacral corsets	17	Blood pressure monitor		
18	Other (specify) ______________				

DETAILS OF CHRONIC APPLIANCE REQUIRED

Trade name of appliance	Conditions for which prescribed	Date of diagnosis	Anticipated duration

PRESCRIBING DOCTOR'S SIGNATURE: ______________ DATE D D M M C C Y Y

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