Request for extended supply of medicine 2019

Discovery
Health Medical Scheme

Who we are

Discovery Health Medical Scheme (referred to as 'the Scheme'), registration number 1125, is the medical scheme. This is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the administrator') is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Discovery Health Medical Scheme and takes care of the administration of your membership.

Contact us

Tel (Members): 0860 99 88 77, Tel (Health partner): 0860 44 55 66, PO Box 784262, Sandton, 2146, www.discovery.co.za, 1 Discovery Place, Sandton, 2196

Purpose of the form

This is an application to ask for an extended supply of chronic or acute medicine.

We will review this request only when you need the extra supply of chronic or acute medicine because you will be outside the borders of South Africa for longer than one month, or up to and no longer than six months. Please note: the maximum period for extended supply of medicines we will consider is six months. We will decline requests for periods longer than six months.

If you change your plan, cancel your Scheme membership or if your membership is suspended during the period for which we have approved your extended supply of medicine, you may have to pay the costs yourself or we may need to recover the money from you. Make reference to the footnote that indicates the expiry date of the form. Download the latest version of all forms from www.discovery.co.za, under Medical Aid > Find a document.

What you must do

- You need to apply at least **seven working days** before you travel.
- Complete one application form for each applicant.
- Fill in the form in black ink and print clearly, or complete the form digitally.
- All relevant sections must be physically signed by the main member and cannot be signed digitally. The main member must sign and date any changes.
- If the applicant is under 18, a parent or legal guardian must complete Section 1 and sign the application form. The primary applicant must complete Section 2. To avoid administration delays, please ensure this application is completed in full.
- Please fax the completed and signed form to **011 539 7004** or email it to **chronicqueries@discovery.co.za**

Please note

This is an approval for funding only and does not override any legal requirements that your pharmacist must comply with. You will need to have a valid prescription for the requested medicine and there are some medicines where the maximum quantity that can be dispensed is a 30 day supply.

Please also check the Customs requirements and laws of the country you are visiting before you travel to avoid any issues with travelling with your medicine.

1. About the main member and applicant

Title _____ Initials _____ Surname _____

First name(s) (as per identity document) _____

Name of applicant _____ Membership number N N N N N N N N N

ID number N N N N N N N N N N N N N Relationship to main member _____

Telephone (H) _____ _____ Telephone (W) _____ _____

Cellphone _____ _____ Fax _____ _____

Email _____

Date of departure Y Y Y Y M M D D Date of return Y Y Y Y M M D D

Destination _____

Preferred method of communication ☐ Email ☐ Fax

2. Medicine requested

Please include the medicine details in the table below. Enter only one medicine per line.

	Medicine name	Chronic or Acute	NAPPI code	Quantity
Medicine 1				
Medicine 2				
Medicine 3				
Medicine 4				
Medicine 5				
Medicine 6				
Medicine 7				
Medicine 8				
Medicine 9				

3. About the provider

Healthcare professional _____

Pharmacy name _____

Pharmacy practice number N N N N N N N N N

Telephone _____ _____ Fax _____ _____

Contact person _____

Signed at (town or city) _____ on Y Y Y Y M M D D

Signature of main member _____ Date Y Y Y Y M M D D

⚠ **Please only sign if information is true, complete and correct.**

Signature of applicant or legal guardian, if applicable _____ Date Y Y Y Y M M D D

⚠ **Please only sign if information is true, complete and correct.**