UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

UKZN MEDICAL SCHEME
Administered by Discovery Health

Contact details
Tel: 0860 11 33 22, PO Box 652509, Benmore 2010, www.discovery.co.za

Request for extended supply of medicine 2017

Who we are

The University of KwaZulu-Natal Medical Scheme (referred to as 'the Scheme'), registration number 1520, is a non-profit organisation, registered with the Council for Medical Schemes.

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

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 cancel your membership or your membership is suspended during the period for which we have approved your extended supply of medicine, you will have to pay the costs yourself or we may need to recover the money from you.

Follow these steps to help us process your application:

- You need to apply at least 7 working days before you travel.
- Please use one letter per block, complete with black ink and print clearly.
- To avoid administration delays, please ensure this application is completed in full.
- Complete one application form for each patient.
- Please fax the completed and signed form to **011 539 7004** or email it to **chronicqueries@discovery.co.za**.
- 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.
- Both the applicant and the parent or legal guardian (if applicable) must sign the application form.

1. About the main member and patient

Main member name and surname

Patient name and surname

Membership number

ID number

Relationship to main member

Telephone (H)

(W)

Cellphone

Fax

Email address

Date of departure 2 0 Y Y M M D D

Date of return 2 0 Y Y M M D D

Destination

Preferred means of communication Email ☐ Fax ☐

2. Medicine requested

Please insert the chronic medicine or acute medicine details in the applicable section 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

Telephone

Fax

Contact person

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

Signature of main member

Signature of patient or legal guardian, if applicable

Date Y Y Y Y M M D D

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