PROFMED

REQUEST FOR EXTENDED SUPPLY OF CHRONIC MEDICATION

You may request an extended supply of medication up to a period of 5 months.

To avoid administration delays, please ensure this application is completed in full.

To be completed and returned to the administrator at least 7 days before you are due to collect your extended supply of chronic medication from your pharmacy.

Please email the completed form to **chronic@medikredit.co.za**.

1 MEMBER INFORMATION

Member number

Telephone: Work Home

Cell

Email address

Name of the principal member

Name(s) of dependants who are travelling

2 TRAVEL INFORMATION

Departure Date Return Date

I will require _____ (number of months) extended supply of my chronic medication and I will be collecting the medication from _____ (pharmacy name) between the following dates _____ and _____.

(Please supply the dates within a 5-day period that will be convenient for you to collect the extended supply of chronic medication from the pharmacy. Only approved chronic medication will be provided as an extended supply and not acute medication).

3 MEDICATION INFORMATION

Please attach a prescription listing the required medication for the duration of your travel period, alternatively complete the table below.

Note: The medication can only be claimed within this 5-day period.

PLEASE LIST THE MEDICATION REQUIRED		
Name of patient	**Name of medication**	**Strength and dosage**

Note: Remember to apply for a sufficient repeat of medication for the duration of your travel period.

4 INDEMNITY

This is to certify that I, (principal member's name and surname) _____

residing at (address) _____

do hereby confirm that I am willing to accept liability for the full payment of the extended prescription for the period of _____ months, namely duration of the extended supply of medicine, in the event of me ceasing to be a member of Profmed prior to the expiry of the said prescription.

Signed on this _____ day of _____ 20 _____

Signature of member _____