Pick n Pay

Medical scheme

PSYCHIATRIC APPLICATION FORM
OUTPATIENT MENTAL HEALTH BENEFITS

For out-of-hospital psychotherapy sessions in lieu of hospitalisation, we require the treating physician to kindly complete this form and return it to the details provided at the end of this form.

PLEASE USE BLOCK LETTERS FOR ALL SECTIONS

***Compulsory fields**

1. MEMBER AND PATIENT INFORMATION

MAIN MEMBER DETAILS

Membership number | Benefit option

Title | Initials | ID number*

Full name and surname

Email address

PATIENT DETAILS

Dependant code

Title | Initials | ID number*

Full name and surname

Contact numbers | Home | Work

Cell phone

Postal address

Postal code

Email address

2. MEDICAL PRACTITIONER'S INFORMATION

DOCTOR DETAILS

Practice number

Initials | Speciality

Surname

Contact numbers | Work | Fax number

Cell phone

Postal address

Postal code

Email address

Membership number | **Doctor's practice number**

3. CLINICAL INFORMATION

Date of diagnosis | D | D | M | M | Y | Y | Y | Y |

ICD-10 code(s)

Consultation/procedure code(s)	Quantity requested

CURRENT MEDICATION

CLINICAL INDICATION/MOTIVATION

Referring doctor's signature

Date D D M M Y Y Y Y

Membership number

Doctor's practice number