Pick n Pay

Medical scheme

APPLICATION FORM
ADVANCE SUPPLY OF CHRONIC MEDICATION

Please complete this application form if you have any circumstances, such as plans to travel outside of the country for an extended period, and you need to request an advance supply of medication from your doctor/pharmacy. Please provide supporting documentation as proof, such as flight bookings.

PLEASE USE BLOCK LETTERS FOR ALL SECTIONS

1. DETAILS OF APPLICANT

Membership number		Benefit option ☐ Primary Option ☐ Plus Option	
Full name and surname		Dependant code	
Identity number		Contact number	
Email address			

2. PRESCRIPTION DETAILS

Reason for advance supply request

Medication name and details

Time period of advance supply required (days/weeks/months)

I hereby confirm that, in the event that I am no longer a member of Pick n Pay Medical Scheme prior to the expiry of this prescription, I am willing to accept liability for the full payment of the extended prescription for the period indicated.

Member's signature		Witness' signature	
Date	DD/MM/YYYY	Date	DD/MM/YYYY

Please return the completed form by email to enquiries@pnpms.co.za.

Protection of Personal Information
Pick n Pay Medical Scheme and Momentum Health Solutions, the Administrator, will maintain the confidentiality of your personal information and comply with the Protection of Personal Information Act 4 of 2013 (POPIA) and all existing data protection legislation, when collecting, processing and storing your personal information for the purposes of this application.

08/2023

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