Bankmed
Yours in good health

Contact us
Tel: 0800 BANKMED (0800 226 5633) • Private Bag X2, Rivonia 2128 • www.bankmed.co.za

Request for extended supply of medication

Who we are

Bankmed (referred to as 'the Scheme'), registration number 1279, 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) which takes care of the administration of your membership for the Scheme.

Purpose of the form

This is an application for members on the Bankmed Essential or Basic Plans to request an extended supply of chronic medication and for members on all Bankmed Plans to request an extended supply of HIV or Oncology medication.

We will review this request only when you need an additional supply of Chronic, HIV or Oncology medication in the event that you will be outside the borders of South Africa for longer than one month, or up to six months. Please note: extended medication supply will only be considered up to a maximum period of six months.

Should you change to a Plan with lesser benefits or you cancel your Bankmed membership or should your membership be suspended during the period for which we have approved your extended supply of medication, you may have to pay the costs yourself or we may need to recover the money from you.

How to complete this form

1. You need to apply at least seven working days before you travel.
2. Kindly use one letter per block, complete with black ink and print clearly.
3. To avoid administrative delays, kindly ensure this form is completed in full.
4. Kindly submit a copy of your travel ticket or itinerary with this application.
5. Complete one application form for each patient.
6. Kindly e-mail this completed and signed form to **chronicbasicessential@bankmed.co.za** for Chronic, HIV, or Oncology requests.
7. If the applicant is under 18, a parent or legal guardian must complete Section 1 and sign the application form.
8. The primary applicant must complete Section 2.

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 medication and there are some medications 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 while travelling with your medication.

1. Principal member details

Membership number

ID or passport number

Member's surname

Member's name

2. Patient's details

Title

Initial(s)

First name(s)

Surname

Membership number

ID or passport number

Relationship to Principal Member

Telephone (H)

Telephone (W)

Cellphone

E-mail

Date of departure D D M M Y Y Y Y

Date of return D D M M Y Y Y Y

Destination

3. Medication requested

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

	Medication name	Chronic or Acute
Medication 1		
Medication 2		
Medication 3		
Medication 4		
Medication 5		
Medication 6		
Medication 7		
Medication 8		
Medication 9		

Patient's signature

(If patient is a minor, Principal member to sign)

4. Healthcare Professional's details

Name and Surname

Practice number

Speciality

Telephone

E-mail