A member of AfroCentric group

Pharmacy Direct

Caring, Reliable & Affordable

Pharmacy Direct Practice No. 0126225

Postal Address: P.O. Box 7344
CENTURION
0046

Street Address: No. 23 Kwartsiet Crescent
Zwartkop Ext. 5
CENTURION

Please complete this form and fax it to 0866 114 000/1/2
Please dial 0860 027 800 if you need to speak to a customer service agent
Assistance is also available on www.pharmacydirect.co.za or care@pharmacydirect.co.za

Information of Main Member

Initials | 1st Name | Surname

ID No. | Medical Aid

Medical Aid No. | Option | Pensioner Y N

Tel Work – | Home

Cell. – | E-mail

Information of Patient 1

Initials | 1st Name

Surname

Tel Work. –

Cell. –

ID No.

Gender M F | Doctor

Information of Patient 2

Initials | 1st Name

Surname

Tel Work. –

Cell. –

ID No.

Gender M F | Doctor

Address Detail

Home/ Physical Address

Building | Street & No.

Suburb | Town/ City | Postal Code

Postal Address (If different to home)

Line 1 | Line 2

Suburb | Town/ City | Postal Code

Work Address

Building | Street & No.

Suburb | Town/ City | Postal Code

Please deliver to my – Work ☐ Postal Address ☐ Home (Only if someone can receive parcels) ☐

Service Required

Please deliver my medication to the indicated address – Automatically every 28 days ☐ By request ☐

Do you agree to generic substitution? Y N | Do you agree to therapeutic substitution? Y N

My first medication is expected on / / 20 (Subject to Medical Aid approval)

I need my first delivery of medication on / / 20

IMPORTANT: Please note a valid, repeat prescription will be required every 6 months as per legislation

The applicant acknowledges that he/she is responsible for payment of any levies, co-payments or rejections that the medical scheme may impose, and to inform Pharmacy Direct of any changes to his/her medical aid detail.

Signature: Main Member: _____ Date: _____