



Pharmacy Direct Practice No. 0126225  
Postal Address: P.O. Box 7344  
CENTURION  
0046  
Street Address: Block A  
Arena Office Park,  
272 West Road  
CENTURION

Please complete this form and fax it to **086 611 4000/1/2/3** or **(012) 643 3040**  
Please dial **0860 027 800** if you need to speak to a customer service agent  
Assistance is also available on [www.pharmacydirect.co.za](http://www.pharmacydirect.co.za) or [care@pharmacydirect.co.za](mailto:care@pharmacydirect.co.za)

### Principle Member Information

Initials  1<sup>st</sup> Name  Surname   
ID No.  Medical Aid   
Medical Aid No.  Option  Pensioner  Y  N  
Tel Work  Home   
Cell  E-mail

### Patient 1 Information

Initials  1<sup>st</sup> Name   
Surname   
Tel Work.   
Cell.   
ID   
Gender  M  F Doctor

### Patient 2 Information

Initials  1<sup>st</sup> Name   
Surname   
Tel. Work   
Cell.   
ID   
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?  Yes  No Do you agree to therapeutic substitution?  Yes  No

I need my first medication on  /  /20 (Subject to Medical Aid approval)

**You must fax us a copy of your valid prescription and send the original by mail within 30 days**

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.  
Only written cancellations of this application will be accepted.

Main Member Signature \_\_\_\_\_

Date \_\_\_\_\_