LA Health
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Contact us
Tel: 0860 103 933, PO Box 652509, Benmore, 2010, www.lahealth.co.za

Chronic Illness Benefit – Request for extended supply of medicine 2010

This form is used to apply for a sufficient supply of medicine for a period of three months should you be travelling outside the borders of South Africa. Please note: should you leave LA Health within the benefit confirmation period for extended medicine, we will bill you for the remaining months of medicine supplies.

How to complete this application

1. One application form is to be completed per patient.
2. Please attach your air ticket to this document. If you do not have an air ticket, we will require your itinerary, as we are unable to process your request without either your air ticket or itinerary.
3. Please complete all sections of the application in full and fax with your air ticket or itinerary to **011 539 7004.** Incomplete applications will result in administrative delays.
4. If we do not communicate with you within 4 working days from when you return this form, please call us on 0860 99 88 77.
5. Prior benefit confirmation must be obtained from LA Health and claims must be submitted electronically through a MediKredit pharmacy to be paid. (The pharmacy will inform you if they are a MediKredit Service provider.) Formulary medicine will be paid in full up to the LA Health medication rate. Non-formulary medicine will be paid up to the Chronic Drug Amount.

1. About the patient

Patient's name and surname

Membership number

Telephone (H)

Telephone (W)

Fax

Cellphone

Email address

Date of birth Y Y Y Y M M D D

Date of departure Y Y Y Y M M D D

Date of return Y Y Y Y M M D D

Preferred means of communicating your confidential information email ☐ or fax ☐

2. About the main member (if patient is a minor)

Main member's name and surname
(as per identity document)

Membership number

Date of birth Y Y Y Y M M D D

Telephone (W)

Telephone (H)

Cellphone

Fax

Email address

Preferred means of communicating your confidential information email ☐ or fax ☐

Date of departure Y Y Y Y M M D D

Date of return Y Y Y Y M M D D

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3. About your medicine request

	Medicine name
Medicine 1	
Medicine 2	
Medicine 3	
Medicine 4	
Medicine 5	
Medicine 6	
Medicine 7	

4. About your medicine provider

Pharmacy name

Practice number

Telephone

Fax

Contact person

Patient's signature
(main member's signature if patient is a minor)

Date Y Y Y Y M M D D

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