



Chronic Appliance Benefit Application Form

TO BE COMPLETED BY APPLICANT

MEMBER DETAILS:

PLAN

MEMBERSHIP NUMBER

SURNAME

TITLE INITIALS ID NUMBER

E-MAIL ADDRESS

PATIENT DETAILS:

SURNAME

FIRST NAME TITLE

ID NUMBER

ADDRESS

E-MAIL ADDRESS

TELEPHONE (W) (H) CELL

I authorise my medical practitioner to furnish and/or disclose to Bankmed any fact relating to this application as well as any additional information that may be required from time to time. (Remember that your medical practitioner bears the responsibility of prescribing the appliance for you, irrespective of the benefit authorised.)

MEMBER'S SIGNATURE _____ DATE

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

DOCTOR DETAILS:

SURNAME INITIALS

PRACTICE NUMBER SPECIALITY

TELEPHONE FAX CELL

POSTAL ADDRESS CODE

E-MAIL ADDRESS

