

APPLICATION FORM ADVANCE SUPPLY OF CHRONIC MEDICATION

Please complete this application form if you have any circumstances, such as plans to travel outside of the country for an extended period, and you need to request an advance supply of medication from your doctor/pharmacy. Please provide supporting documentation as proof, such as flight bookings.

1. DETAILS OF APPLICANT

Membership number	<input type="text"/>	Dependant code	<input type="text"/>
Full name and surname	<input type="text"/>		
Identity number	<input type="text"/>	Contact number	<input type="text"/>
Email address	<input type="text"/>		

2. PRESCRIPTION DETAILS

Reason for advance supply request

Medication name and details

Time period of advance supply required (days/weeks/months)

I hereby confirm that, in the event that I am no longer a member of BP Medical Aid Society prior to the expiry of this prescription, I am willing to accept liability for the full payment of the extended prescription for the period indicated.

Member's signature	<input type="text"/>	Witness' signature	<input type="text"/>
Date	<input type="text"/> DD/MM/YYYY	Date	<input type="text"/> DD/MM/YYYY

Please return the completed form by email to mrm@bpmas.co.za.

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12/2021

Medicine Risk Management Programme