



PROFESSIONAL PHARMACISTS YOU CAN TRUST

ing (Pty) Ltd t/a Medirite
number: 1998/012354/07

arl & William Dabs Rds
l 7561
South Africa

PO Box 1575
Brackenfell 7561
Cape Town, South Africa

ite.co.za

(021) 983 5119/6
email: mediritechronic@shoprite.co.za

Medirite Member Registration Form

Principal Member Details

Surname	
First names	
Date Of Birth	
I.D. Number	
Medical Scheme + Option or Plan	
Membership Number + code	
Telephone Home	
Telephone Work	
Cell Phone Number/s	
Physical Address	
Delivery Address	
E-Mail	

Patient 1 Details

Surname			
First names			
Date Of Birth			
I.D. Number			
Dependant Code			
Telephone Home			
Telephone Work			
Cell Phone Number/s			
E-Mail			
Preferred method of delivery	<table border="1"> <tr> <td>Pick-up at Pharmacy</td> <td>Courier (> 10km from pharmacy)</td> </tr> </table>	Pick-up at Pharmacy	Courier (> 10km from pharmacy)
Pick-up at Pharmacy	Courier (> 10km from pharmacy)		

Select one

Patient 2 Details

Surname			
First names			
Date Of Birth			
I.D. Number			
Dependant Code			
Telephone Home			
Telephone Work			
Cell Phone Number/s			
E-Mail			
Preferred method of delivery	<table border="1"> <tr> <td>Pick-up at Pharmacy</td> <td>Courier (>10km from pharmacy)</td> </tr> </table>	Pick-up at Pharmacy	Courier (>10km from pharmacy)
Pick-up at Pharmacy	Courier (>10km from pharmacy)		

Select one

PLEASE FAX THE COMPLETED FORM TO (021) 980-6780

In the event of my medical aid not reimbursing Medirite for medication supplied to me, or any of my dependants, I confirm that I will take full responsibility for the amounts owed to Medirite.

If the preferred method of delivery is the courier service, and there is any levy and/or co-payment, then Medirite will contact the member with the payment procedure and banking details.

Courier deliveries may take up to five working days after confirmation of receipt. Only valid prescriptions will be accepted

SIGNATURE OF MEMBER

DATE:

_____	_____
-------	-------

