Medirite Pharmacy

Medirite Pharmacy Practice No. 925055

Postal Address: PO BOX 23297
GEZINA
0031

Street Address: 387 Taljaard Str
Hermanstad
Pretoria, 0082

Customer Service: 080-001 0701

Fax number: 012-349 8027

COURIER PHARMACY REGISTRATION FORM

Please complete this form and email to : medirite.courier@shoprite.co.za

INFORMATION OF MEMBERS

Initials	First Name	Surname	
ID No.		Medical Aid	
Medical Aid No.		Option	
Tel Work		Home	
Cell		Email	

Patient 1

Initials	First Name	Surname	
Tel Work		Cell	
ID No.		Gender	M F
Doctor			

Patient 2

Initials	First Name	Surname	
Tel Work		Cell	
ID No.		Gender	M F
Doctor			

Address Details

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 (please phone me) ☐

Do you agree to generic substitution Y N

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

IMPORTANT: Please note a valid, repeatable prescription will be required every 6 months as per legislation

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 Medirite Pharmacy of any changes to his/her medical aid detail

Consent

I hereby give MediRite Pharmacy authorisation to access, store and process my/our family members' personal information for the below purposes:

- To prepare my/our family members' monthly prescription(s), as per the original repeat prescription(s) provided by me/our family members to Medirite and deliver it via the selected courier to my preferred address; and
- Contact me directly with regards to my/our family members' prescription medication requirements; and
- Contact me directly with regards to health and other related information.

I confirm that I am the main medical aid member/contact person for this family and duly authorised by my family members to request this service on their behalf.
I understand that I can contact MediRite personally or telephonically if I wish to opt out of this service and that it will take 7 days for this to become effective.

Signature: Main Member: Date: