PLEASE PROVIDE THE INFORMATION BELOW IN ORDER THAT WE CAN APPLY FOR PRE AUTHORISATION FOR YOUR ADMISSION TO TREATMENT. YOU ARE UNDER NO OBLIGATIONS AND YOU CAN ALWAYS DECLINE ADMISSION, IF YOU CHANGE YOUR MIND.

NAME OF PATIENT	
DATE OF BIRTH	
IDENTITY NUMBER	

MEDICAL AID	
MEDICAL AID NUMBER	
MEDICAL AID PLAN	

MAIN MEMBER NAME	
MAIN MEMBER IDENTITY NUMBER	
MANI MEMBER DATE OF BIRTH	
MAIN MEMBER TELEPHONE NUMBER	
MAIN MEMBER EMAIL ADDRESS	

Our administration will contact you as soon as we know whether benefits are available for this admisssion