APPLICATION FOR MEDICINE-SUPPLY ADVANCE

1. APPROVAL PROCESS

IMPORTANT:

Please complete below and return to Bestmed at least two weeks prior to the date of medicine collection:

- The information can be e-mailed to medicine@bestmed.co.za or faxed to +27 12 472 6760.
- **Please attach a copy of your flight ticket or travel document to this application.**
- **Please attach a copy of the prescription for the medicine required for collection.**
- Once the information is received, you will be contacted within 48 hours, by e-mail. If you have not been contacted after 48 hours, please follow up via e-mail or telephone on 086 000 2378.

*** Incomplete applications will not be considered.**
*** No telephonic requests can be accommodated.**

2. APPROVAL CONDITIONS

Bestmed can grant approval for a member to claim for an advanced supply of medicine in the following instances:

- If the member is going to a destination across the local border.
- If the member is going overseas.
- If the member is going to a destination where there is no pharmacy in the nearby vicinity (e.g. Kruger National Park).

Please note that Bestmed will not grant approval for an advanced supply of medicine when members are travelling within the borders of South Africa.

Authorisation can only be granted for benefits applicable to the current year's benefits. Any request for the following benefit year will not be considered.

3. APPLICATION DETAILS

Membership number | | | | | | | | | | | | | Dependant code | |

Surname | | | | | | | | | | | | | | | | | | | | | | | | |

First name | | | | | | | | | | | | | | | | | | | | | | | | |

Destination of travel | | | | | | | | | | | | | | | | | | | | | | | | |

Departure and return dates D D M M Y Y Y Y D D M M Y Y Y Y

Are you flying? Yes / No — If yes, please attach flight ticket.

Self-drive trip? Yes / No — If yes, please attach travel document.

Number of months' supply of required medicine | |

Specify the date on which the medicine is to be collected D D M M Y Y Y Y

List the medicine required (acute and chronic) below. Only the medicine/s listed below will be considered.

Medicine name	Strength	Quantity	Medicine name	Strength	Quantity

Signature

Date