primecure

Optometry Authorisation Form

A Member/Policyholder Details:

Principal Member/Policyholder Details:		Patient Details:	
Surname:		Surname:	
Name:		Name:	
Initials:		Initials:	
Dependant No:		Dependant No:	
Occupation:		Occupation:	
Age:		Age:	
Identity Number:		Identity Number:	
Tel No (Work/Home):		Tel No (Work/Home):	
Cell:		Cell:	
Medical Aid/Health Insurer No:		Medical Aid/Health Insurer No:	
Medical Aid/Health Name:		Medical Aid/Health Name:	
Medical Scheme/Health Insurer Plan:		Medical Scheme/Health Insurer Plan:	

Tested by: _____ Optometrist Sign: _____

Optometrist (Full Name)

B Declaration by Patient:

I the undersigned, _____ hereby confirm that:

- ◯ I attended the consultation as dated
- ◯ I was shown the specified range of frames applicable to my optical benefit
- ◯ I am satisfied with the scripts as determined during the consultation
- ◯ I understand that if I choose a frame or other extras outside the standard benefit, that I am personally liable for the applicable co-payment of R _____

Date: y y y y - m m - d d Signature _____

Practice Name:	
Practice Number:	
Fax Number:	
Authorisation No:	
Date of Consultation:	

Present RX	Sph	Cyl	Axis	Δ	Base	Add	VA
R:							
L:							

Unaided VA:	Distance	L:		Near	L:	
		R:			R:	

New RX	Sph	Cyl	Axis	Δ	Base	Add	VA
R:							
L:							

CR39			Glass
SV	BF	TF	MF
Prox			
P.D. Distance	P.D. Near	SEG. HT. R	SEG. HT. L
Tint	Coat	Other	Blank Size

Frame Details	Mod		Col		Cost	R

C Benefit Authorised:

Eye Test:		R
Single Vision Package:		R
Bifocal Package:		R
Multifocal Package (Suremed Only):		R
Authorisation No:		

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Address: 2nd Floor, The Oval - East Wing, Wanderers Office Park, 52 Corlett Drive, Illovo, 2196
0861 665 665 I provider.loading@primecure.co.za I www.primecure.co.za
Group Directors: J Jutzen, M Jordan
Non-Executive Directors: K Bouic, Z Omar
Registered Company Name Kaelo Prime Cure (Pty) Ltd I Reg. No. 1997 / 017429 / 07

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