Pick n Pay Medical scheme

pha PRIVATE HEALTH ADMINISTRATORS

# Application for Registration on the Pick n Pay Mental Wellness Programme

Membership Number _____ Date _____

Surname _____ First Name/s _____

Home Phone _____ Work Phone _____ Shop/Department _____

Cell Phone _____ Alternate contact number _____ e-mail Address _____

Please specify your condition: _____

When were you diagnosed? _____ Do you take chronic medicines? ◯ yes ◯ no

Postal Address where we can send you information

_____

Doctor's Name _____ Doctor's Telephone Number _____

N.B. In order to register you on the programme and/or consider chronic medication benefits, we need your doctor to confirm your diagnosis and complete a treatment plan document that includes the DSM IV (Diagnostic and Statistical Manual of Mental Disorders™) multiaxial assessment system criteria together with your latest prescription and treatment history.

May we contact your doctor directly for information? ◯ Yes ◯ No

Please sign here: _____

ALL THE INFORMATION YOU GIVE US WILL BE KEPT STRICTLY CONFIDENTIAL AND WILL NOT BE SHARED WITH YOUR EMPLOYER OR ANYONE OTHER THAN YOUR DOCTORS AND PHARMACY WITHOUT YOUR PERMISSION.

**Please return this form to the Pick n Pay Mental Wellness Programme:**
**By e-mail – pnpwell@pha.co.za or Fax: 086 539 1765**