primecure
healthcare management

Optometry Authorisation Form

A Member Details

Principal Member 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 No		Medical Aid No	
Medical Aid Name		Medical Aid Name	
Medical Aid Option		Medical Aid Option	

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 aplicable 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		
Authorisation No		

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Kaelo Risk (Pty) Ltd is an authorised financial services Provider FSP: 36931, underwritten by Centriq Insurance Company Limited FSP 3417.

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