

Mx HEALTH: COVER SHEET FOR MEDICAL ADVISORY MOTIVATIONS

RETURN FORM TO: MAS DEPARTMENT BOX 7714 CENTURION 0046. FAX (012) 673 5511/2. CONFIRMATION AT (012) 673 8585

Section A – (Member to complete)

1. Patient particulars (user)			
Surname			
First name			
Change of postal Address		Membership no	Dependant
		Tel (home) code	
	Area code	Tel (work) code	

2. Principal member particulars			
Surname		Title	Initials
Fax code / no	No	Cell phone	

Section B – (Provider to complete)

3. General information on services applied for:			
Description of service(s)	NRPL code / product / nappi code	Diagnosis code & description	Cost /quotation
			R
			R

4. Details of additional suppliers or facilities:			
Hospital / Rehabilitation		Contact person	
Tel (Code)		Fax (Code)	

Details of other suppliers: (provider to claim for items/services – (attach prescription where appropriate)

Orthotist/Wholesaler Prosthetist /Pharmacy		Practice number	
Tel (Code)		Fax (Code)	

5. Additional information required for specific services. Please attach to the cover sheet

The following table explains additional requirements for specific services as indicated with an X.

	SERVICES:	Assistive devices	Breast reductions	Breast reconstruction	CPAP machines	Dermatology	Glucometer	Hearing aids	Maxillo facial	Nebuliser / Oxygen	Orthopaedic items	Plastic surgery	Refractive surgery	Scans: MRI, CT	From 3 rd ultra sound	Squint repair	Special dentistry	Stoma products	Transplants	Wound care in lieu of hospital	Wound care/products
REQUIREMENTS:																					
Audiogram							X														
Body Mass Index (length & weight)		X																			
Bra size and sternum/nipple distance in cm		X																			
Clinical motivation		X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X
Pathology			X			X													X		
Photographs (squint - only for patients older than 10yrs)		X	X									X				X				X	
NRPL codes / product codes / nappi codes		X	X		X				X		X	X	X	X	X	X	X	X		X	X
Refractive error													X								
Quotation/Cost analysis		X		X	X	X	X	X	X	X	X	X		X				X	X		X
Sleepstudy: Apnoea/Hypoapnoea l/hr and de-saturation				X																	

6. Particulars of treating provider:			
Referring provider		Discipline	
Treating provider		Discipline	
Address			Area code
HPCSA number		Tel (code) and number	
Practice number		Fax (code)	
Date		Qualification	
Signature		e-mail address	

