UMHLANGA EYE INSTITUTE

PR Number: 0654736

Email: info@umhanga-eye.co.za Reception (T): 031 536 -1800/1803

Admitting Dr: _____ Practice Number: _____

Date of Procedure: _____

Main Members Name & Id Number: _____

Patients Full Name & Id Number: _____

Patient Address: _____

Patient Contact Number(s): _____

Medical Aid Name & Option: _____

Medical aid Number: _____

Procedure: _____

Injection & Nappi code (Delete if not applicable)

_____

ICD10 codes: _____Visual Acuity: _____

Procedure codes: _____

Other Comments

_____

_____

I consent to Umhlanga Eye Institute obtaining authorisation with my Medical aid for the above procedure.

Patient signature: _____

PLEASE EMAIL COPY OF MEDICAL CARD

Office use only

Date & Time auth obtained _____

Auth Number / Reference number _____

Co Payment:_____