BUSAMED
MODDERFONTEIN PRIVATE HOSPITAL
ORTHOPAEDIC & ONCOLOGY CENTRE

Busamed Pre-Admission Form

Please fax/e-mail completed form to

- **Fax** : 011 458 2301
- **Email** : bmphconfirmations@busamed.co.za

Patient Information

First Name

Surname

Identity Number

E-mail Address

Home Telephone Number

Cell Phone Number

Home Address

Postal Address

Religion

Employer's Name

Occupation

Company address

Work Telephone Number

Medical Aid Details

Medical Aid Name

Membership Number

Plan

Dependant Code of Patient

Main Members Details (do not complete if same as patient)

First Name

Surname

Identity Number

E-mail Address

Home Telephone Number

Cell Phone Number

Home Address

Employer's Name

Occupation

Company address

Work Telephone Number

Next of Kin

1st Contact Person

Full Name

Relationship

Contact Number

Address

2nd Contact Person

Full Name

Relationship

Contact Number

Address

Doctors Details

Admitting Doctor

Referring Doctor

Family/House

Admission Details

Admission Date

Procedure/Diagnosis

ICD 10 Codes

Procedure Codes

Authorisation Number

Co-payment/Deductible

I _____

Hereby confirm that the above information is correct.

Full Name : _____

Signature : _____

Date : _____

Please contact the hospital to obtain an estimated cost for your admission. Please note that private paying patients and any medical aid co-payments/deductibles are required to be settled prior to admission.

Documents required on admission:

- Original medical aid card/membership certificate.
- ID document of patient and main member.