THE CEDARS GROUP

Please provide the information below so that we can apply on your behalf for pre-authorisation for your admission to treatment. You are under no obligation to proceed with admission as a result of completing this form. Your information will remain confidential and will not be shared with any third-party beyond your indicated medical aid provider.

NAME OF PATIENT	
DATE OF BIRTH	
IDENTITY NUMBER	

MEDICAL AID	
MEDICAL AID NUMBER	
MEDICAL AID PLAN	

MAIN MEMBER NAME	
MAIN MEMBER IDENTITY NUMBER	
MANI MEMBER DATE OF BIRTH	
MAIN MEMBER TELEPHONE NUMBER	
MAIN MEMBER EMAIL ADDRESS	

A member of our administration team will contact you as soon as receive feedback regarding your request for cover from your medical aid provider.

Please email a completed copy of this form to bookings@thecedars.co.za

Thank you,

The Cedars Group