Intercare Irene: Tel 021 276 1066

Intercare Glen Marais: Tel 021 276 1067

Intercare Woodhill: Tel 012 276 1062
Moreleta Park, Woodhill

Intercare Linden Lanes: Tel 010 035 6970
Corner 6th Street and 3rd Street, Linden, Randburg

Intercare Wonderboom: Tel 021 276 1063

Intercare Mall@55: Tel 021 276 0727

Intercare Castle Gate: Tel 012 276 1061
Waterkloof Ridge, Castle Gate

Bedfordview Intercare: Tel 010 746 6265
1st Floor, Village View Centre, 41 Van Buuren Rd,
Bedfordview, Germiston

Practice Number: 3803465 | Email: accounts@bergmanross.co.za

DR J.W. BERGMAN | DR J.L. ROSS | DR B.A. COTTON | DR J.V. BEKKER | DR J.C. BASSON
DR Y. VADACHIA | DR M.A. HAYES | DR A.D. BRANDT | DR A. SABAN | DR S. FAYKER

REQUEST FOR IMAGING EXAMINATION

Date:	Date of birth:
Name:	ICD 10 Code:
Medical Aid:	Medical Aid No.
Dependant Code:	
Tariff Code:	Authorisation No.:

PLEASE INDICATE WHICH BRANCH:

- ☐ INTERCARE WONDERBOOM
- ☐ INTERCARE MALL @ 55
- ☐ INTERCARE IRENE
- ☐ INTERCARE WOODHILL
- ☐ INTERCARE CASTLE GATE
- ☐ INTERCARE GLEN MARAIS
- ☐ INTERCARE LINDEN LANES

EXAMINATION:

- ☐ X-RAY

CLINICAL PARTICULARS

REFERRING DOCTOR: _____ TEL NO.: _____

SIGNATURE: _____ EMAIL: _____

PRACTICE NO.: _____ RESULTS.: EMAIL _____

FEMALE PATIENTS: ARE YOU PREGNANT? YES | NO

INDEMNIFICATION AND CONSENT

I confirm that the information supplied is true and correct. I agree and understand that:

- The member will carry all costs/ penalties incurred as a result of failed pre-authorisation. Should legal steps be instituted for the collection of outstanding funds, I shall be liable for costs of an attorney/ client scale.
- Notwithstanding any Medical Aid Society or other organisation's undertaking, I acknowledge personal responsibility for the payment of the account within 30 days. As a Private Patient/ without a valid medical aid, I agree to pay for the procedure/examination on the day.
- I authorise and give consent to Bergman Ross & Partners to release my medical reports. Diagnostic images and referral letters for the purpose of mediation my adiology account with my medical aid, as well as government institutions for statistical purposes.
- All procedures performed at this facility will be online and available to a restricted community of clinicians. I hereby give consent for my radiology images and reports to be released to all 3rd parties forming part of my circle of healthcare as per conditions of the POP (PAIA) Act of 2013.

Patient Signature: _____ **Patient Name:** _____ **Date:** _____