

# AUTOSTATEMENT TERMINATION FORM

## PHARMACY AUTOSTATEMENT INFORMATION

Pharmacy Name:  
(BHF Registration Name)

Pharmacy  
BHF Number:

Requested  
Termination Date:

DD/MM/YYYY

(Please note that termination forms received and captured by MediKredit by close of business before or on a Wednesday, will result in your Pharmacy's reconciliation data no longer being released as part of the Vendor Autostatement as of Friday of the subsequent week) **Cannot be backdated.**

## PREVIOUS PHARMACY VENDOR INFORMATION

Autostatement Group that the pharmacy should be terminated from: (Please select below)

  
  
  
  

Allegra (ALEG)

ASSIST (Admin-e-Strators)

BUSA (Busamed Pharmacies)

CKSA (BCX/Unisolv)

CLIC (Clicks)

  
  
  
  

COMC (CompCaps)

VEXAL (Vexall)

PONE (Pharmacy One)

PRAS (Propharm)

TRIF (Trifour)

### PHARMACY SIGNATURE

Please sign in full: Who by his/her signature hereto warrants that he/she is duly authorised to bind the Pharmacy.

Name of signatory

Designation of signatory

### VENDOR SIGNATURE

Please sign in full: Who by his/her signature hereto warrants that he/she is duly authorised to bind the Vendor.

Name of signatory

Designation of signatory

Once the form has been completed and signed **by the provider** the form must be emailed to the selected vendor.

### PLEASE NOTE:

Once the vendor has signed the form the vendor needs to forward it to [implementationsdept@medikredit.co.za](mailto:implementationsdept@medikredit.co.za).