INDIVIDUAL HEALTH ASSESSMENT
CONSENT FORM

taking care of our own

PO Box 2338, Durban 4000 | Tel: 0861 000 300 | Fax: 031 580 0429 | Email: info@mhcmf.co.za

Important notes:
Moto Health Care (MHC) members receive **one free health assessment** from the wellness programme benefit. This benefit is for members and/or dependants who are 21 years and older.

Please obtain pre-authorisation for this assessment through the self-service option by logging onto the Scheme's website at www.mhcmf.co.za. You may also contact the call centre on 0861 000 300 or email info@mhcmf.co.za.

This health assessment can be done at affiliated pharmacies. The results will be submitted directly to MHC. If this test was done at a general practitioner, please note that the consultation fee will be processed from your day-to-day or savings benefit.

For general practitioner billing purposes, kindly use tariff code 969220. The health assessment tariff code is not billed with the consultation tariff code. For pharmacy billing purposes, please use nappi code 711326001.

This form must be completed in full and returned by email to info@mhcmf.co.za or by fax to 031 580 0429.

Member number ____________________

Gender Male ☐ Female ☐

Title ____________ Initials ____________

Name ____________________

Surname ____________________

Date of birth ____________________ DD/MM/YYYY

Identity/Passport number ____________________ Country of issue ____________________

Cell phone number ____________________

Email address ____________________

SECTION 1: BIOMETRIC INFORMATION (ALL FIELDS LISTED BELOW ARE COMPULSORY)

Height ____________ metres

Weight ____________ kilograms

Waist circumference ____________ centimetres

Cholesterol ____________ mmol/l

Blood pressure Systolic ____________ mmHg

Diastolic ____________ mmHg

Pregnant Yes ☐ No ☐ (or up to 6 months postpartum)

If you are pregnant, please complete your height, weight and waist circumference. We will not use these measurements to calculate your healthy heart score.

I consent that the biometric results will be disclosed to MHC, my medical scheme administrator, my employer and the occupational health staff at my employer.

I understand the purpose and benefit of such a test is to determine my healthy heart score and MHC and my medical scheme administrator will store the data on their database to assess my health risk. Additionally, this data will be shared with my employer and the occupational health staff at my employer to help in programmes to understand my health status and improve it. These entities will keep the results confidential and will not disclose results to third parties without my consent and will implement security measures against unauthorised processing by any third party.

Section 1 continued on page 2

SECTION 1: BIOMETRIC INFORMATION (CONTINUED)

Indemnity

I understand that MHC, its directors and its employees will not accept any responsibility and shall not be liable for any injury, death, illness, loss or other damages of any nature (direct or indirect, special or consequential) suffered or incurred during or resulting from my participation in the aforementioned tests and the use of the results thereof. I have read and understood the above consent, purpose and indemnity.

Signature		Date	DD/MM/YYYY

SECTION 2: SMOKER/NON-SMOKER DECLARATION

Smoker Yes ☐ No ☐

Signature		Date	DD/MM/YYYY

SECTION 3: SIGN-OFF (TO BE COMPLETED BY THE HEALTHCARE PROFESSIONAL)

I declare that I have tested and counselled the member.

Healthcare professional name	
Healthcare professional registered number	
Contact number	

Healthcare professional signature		Date	DD/MM/YYYY