# *MEDICAL BENEFITS SCHEME*

## LETTER OF AUTHORIZATION (A1)

I ______________________________________________ ________________
**(Name of Beneficiary)** **(MBS Number)**

Authorize the following three (3) persons to collect my medication. **

___________________________________

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___________________________________

**(**Authorized person(s) must be over twelve (12) years old.)**

Signature of Beneficiary: _________________________________ Date: ____________

Address: ______________________________________________________________

Telephone No.: ________________________________________ Cell: ____________

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Witnessed by: ……………………………………………………………………………………
**(Print full Name) -** ***Authorized persons and the beneficiary cannot witness this form.***

Signature: …………………………………….……………. Date: …………………..……..……

Address: ………………………………………………………………………………………

Telephone No.: …………………………………………….. Cell: ………………………. ………..………

**Please note that there is a verification process to ensure that the information given is correct.**

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**<u>OFFICIAL USE</u>**

Processed by: ……………………………………………….. Date: ……………………..………

Verified by: ……………………………………..…………. Date: …………..…..………..…

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