PSMAS
PREMIER SERVICE
MEDICAL AID SOCIETY

ONCOLOGY TREATMENT PLAN- RADIOTHERAPY

Name

Membership number **Suffix**

Diagnosis **Histology**

Stage

Tariff	Description	Quantity	Cost per Unit	Total Cost

Number of sessions planned.....

Duration of each session.....

Interval between sessions.....

Any additional therapy.....

Doctor's Name.....

I hereby certify that I,..... Identity number.....

Will be given the treatment stated above. I agree any claim for treatment not given to me will be treated as fraudulent.

Member/Guardian Name (Print).....

Member's/Guardian's Signature.....

STAMP HERE