UCS TS ERA Authorization Form

PHARMACY AUTO-RECON INFORMATION		
Pharmacy Name: (Full Trading Name)		
Contact Person:		
Pharmacy BHF Number:		
Pharmacy CPO Number:		
Postal Address		
Physical Address		
Pharmacy contact's Tel. No	**Code ( )**	**Tel. No:**
Pharmacy contact's Fax. No	**Code ( )**	**Fax. No:**
Pharmacy E-mail Address		

TERMS AND CONDITIONS FOR AUTOSTATEMENTS

- By signing this document you provide your consent that the Medical Scheme/Pharmaceutical Benefit Management Company is authorized to supply UCS TS with reconciliation data pertaining to your pharmacy as per the BHF number specified in this form.
- Please note that UCS TS will make all reasonable efforts to ensure that reconciliation data given by the Medical Scheme/Pharmaceutical Benefit Management Company is accurate.
- UCS TS shall however, not be liable whether in contract, delict or otherwise, for any direct, indirect, special or consequential loss or damage or any loss of profit suffered or sustained by your pharmacy as a result of or in connection with the use of or reliance on incorrect data provided by Medical Scheme/Pharmaceutical Benefit Management Company or your omission to inform us of any change of your pharmacy details.
- UCS TS is responsible for the download of auto reconciliation files into the relevant mailboxes for access by your pharmacy.
- Should the auto reconciliation file be inaccessible, or not available, kindly contact UCS TS in this regard.
- Should the download of the file not be successful i.e. the integration of the file into UNISOLV be unsuccessful, you must contact your vendor for assistance in respect thereof.
- Should the information listed on the auto reconciliation file received from UCS TS, be incorrect in any way, please contact UCS TS on 011-695-5300.
- In the event that your pharmacy terminates with UCS TS, it remains the responsibility of the pharmacy to notify the Medical Scheme/Pharmaceutical Benefit Management Companies.
- Please also note that by affixing your signature hereto, you confirm your acceptance of the above terms and conditions.
- The termination of this contract is subject to notice in writing by either party to the other party of at least one calendar month

SIGNED AT _____ ON THIS _____ DAY OF _____ 20_____

_____
Signature
Pharmacy Owner / Manager
Who by his/her signature hereto warrants that he/she is duly authorized to bind the Pharmacy

Name of signatory:_____

_____
Signature
For : UCS TS
Who by his/her signature hereto warrants that he/she is duly authorized to bind UCS TS

Name of signatory: **DIANA DASS**

Please Fax Back to UCS TS on 011-312 1305