tel **061-285-5400**
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Ausspann Plaza, Unit 2, First Floor
Dr Agostino Netto Road, Ausspannplatz
P.O. Box 23064, Windhoek, Namibia
Reg No: MOHSS 0003

Application for chronic medication

Please note:
In order for the administrator to deliver efficient service to you, it is important that you provide and complete all information as required. Print clearly using capital letters. Only one character per block.

Member Details

Member name					
Member surname					
Title		*Initial*		*Main member Y / N*	
Contact no		*Email*			
Nationality		*Passport no*			
Date of birth		*Gender M/F*		*Employment*	
Membership no		*Dep No*		*Option*	

Additional contact information

Relationship			
Name		*Surname*	
Contact no		*Email*	

Main member details (If applicant is a dependant)

Member name		*Member surname*			
Title		*Initial*			
Contact no		*Email*			
Nationality		*Passport no*			
Date of birth		*Gender M/F*		*Employment*	
Chronic medication					

Condition / Disease – Condition 1

Disease and ICD 10

When was it first diagnosed

Doctor

PR No

Telephone no

Email address

Investigations (please ensure all results are attached to the application)

Follow-up test

Script

Start date

Repeats

Condition / Disease – Condition 2

Disease and ICD 10

When was it first diagnosed

Doctor

PR No

Telephone no

Email address

Investigations (please ensure all results are attached to the application)

Follow-up test

Script

Start date

Repeats

Condition / Disease – Condition 3

Disease and ICD 10

When was it first diagnosed

Doctor

PR No

Telephone no

Email address

Investigations (please ensure all results are attached to the application)

Follow-up test

Script

Start date

Repeats

Condition / Disease – Condition 4

Disease and ICD 10

When was it first diagnosed

Doctor

PR No

Telephone no

Email address

Investigations (please ensure all results are attached to the application)

Follow-up test

Script

Start date Repeats

Condition / Disease – Condition 5

Disease and ICD 10

When was it first diagnosed

Doctor

PR No

Telephone no

Email address

Investigations (please ensure all results are attached to the application)

Follow-up test

Script

Start date Repeats

I, ____, hereby authorise any doctor, hospital, clinic, laboratory, and/or medical facility in possession of my medical records to disclose any relevant medical and historical information to the case manager of my Fund and/or its administrator, on the understanding that such information will be treated as strictly confidential at all times.

I further agree that this authorisation shall remain valid after my death. I indemnify the Fund and/or its administrator against any claims of whatsoever nature arising from, or in connection with, the disclosure of any medical information or test results in accordance with this authorisation. I confirm and warrant that the information provided in this application form is true, accurate, and complete.

____ Signature of patient

____ Date