



We're about you

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P.O. Box 23064, Windhoek, Namibia  
Reg No: MOHSS 0003

# Application for hospital admission (Pre-Authorisation)

## Please note:

In order for the administrator to deliver efficient service to you, please complete all information as required. Print clearly using capital letters. Only one character per block. Leave open one block between words. Mark with an X where necessary.

## Member Details

Member name	<input type="text"/>				
Member surname	<input type="text"/>				
Title	<input type="text"/>	Initial	<input type="text"/>	Main member Y / N	<input type="text"/>
Contact no	<input type="text"/>	Email	<input type="text"/>		
Nationality	<input type="text"/>	Passport no	<input type="text"/>		
Date of birth	<input type="text"/>	Gender M/F	<input type="text"/>	Employment	<input type="text"/>
Membership no	<input type="text"/>	Dep No	<input type="text"/>	Option	<input type="text"/>

## Additional contact information

Relationship	<input type="text"/>		
Name	<input type="text"/>	Surname	<input type="text"/>
Contact no	<input type="text"/>	Email	<input type="text"/>

## Main member details (If applicant is a dependant)

Member name	<input type="text"/>	Member surname	<input type="text"/>		
Title	<input type="text"/>	Initial	<input type="text"/>		
Contact no	<input type="text"/>	Email	<input type="text"/>		
Nationality	<input type="text"/>	Passport no	<input type="text"/>		
Date of birth	<input type="text"/>	Gender M/F	<input type="text"/>	Employment	<input type="text"/>
Chronic medication	<input type="text"/>				

## Hospital information

Name of hospital	<input type="text"/>	Hospital practice number	<input type="text"/>
Email	<input type="text"/>	Date of admission	<input type="text" value="DD / MM / YYYY"/>
Diagnosis	<input type="text"/>	ICD 10 codes	<input type="text"/>
Procedure	<input type="text"/>	Procedure codes	<input type="text"/>
Date of theatre	<input type="text" value="DD / MM / YYYY"/>		

## Service providers

### Admitting doctor

Practice number	<input type="text"/>	Telephone number	<input type="text"/>
Email	<input type="text"/>	Date of service	<input type="text" value="DD / MM / YYYY"/>
Tariff codes	<input type="text"/>	Cost (N\$)	<input type="text"/>

### Anaesthetist

Practice number	<input type="text"/>	Telephone number	<input type="text"/>
Email	<input type="text"/>	Date of service	<input type="text" value="DD / MM / YYYY"/>
Tariff codes	<input type="text"/>	Cost (N\$)	<input type="text"/>

### Surgeon

Practice number	<input type="text"/>	Telephone number	<input type="text"/>
Email	<input type="text"/>	Date of service	<input type="text" value="DD / MM / YYYY"/>
Tariff codes	<input type="text"/>	Cost (N\$)	<input type="text"/>

### Physiotherapist

Practice number	<input type="text"/>	Telephone number	<input type="text"/>
Email	<input type="text"/>	Date of service	<input type="text" value="DD / MM / YYYY"/>
Tariff codes	<input type="text"/>	Cost (N\$)	<input type="text"/>

### Admitting doctor (Secondary / Other)

Practice number	<input type="text"/>	Telephone number	<input type="text"/>
Email	<input type="text"/>	Date of service	<input type="text" value="DD / MM / YYYY"/>
Tariff codes	<input type="text"/>	Cost (N\$)	<input type="text"/>

## Patient consent to obtain medical information and test results

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