We're about you

Application for hospital admission (Pre-Authorisation)

tel 061-285-5400
email preauthorisation@care.nhp.com.na
website www.nhp.com.na

Office 29, First Floor Hilltop Village Mall
Ombika Street Kleine Kuppe,
P.O. Box 23064, Windhoek, Namibia
Reg No: MOHSS 0003

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					
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					

Hospital information

Name of hospital		Hospital practice number	
Email		Date of admission	DD / MM / YYYY
Diagnosis		ICD 10 codes	
Procedure		Procedure codes	
Date of theatre	DD / MM / YYYY		

Service providers

Admitting doctor

Practice number		Telephone number	
Email		Date of service	DD / MM / YYYY
Tariff codes		Cost (N$)	

Anaesthetist

Practice number		Telephone number	
Email		Date of service	DD / MM / YYYY
Tariff codes		Cost (N$)	

Surgeon

Practice number		Telephone number	
Email		Date of service	DD / MM / YYYY
Tariff codes		Cost (N$)	

Physiotherapist

Practice number		Telephone number	
Email		Date of service	DD / MM / YYYY
Tariff codes		Cost (N$)	

Admitting doctor (Secondary / Other)

Practice number		Telephone number	
Email		Date of service	DD / MM / YYYY
Tariff codes		Cost (N$)	

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*