We're about you

tel 061-285-5400
email oncology@care.nhp.com.na
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Office 29, First Floor Hilltop Village Mall
Ombika Street Kleine Kuppe
P.O. Box 23064, Windhoek, Namibia
Reg No: MOHSS 0003

Application for Oncology treatment

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*	

Practice details

Name of practice		*Practice number*	
Contact person		*Telephone No*	
Email address			

Disease information

Diagnosis date | *ICD 10 code*

ICD description | *Morphology code*

Morphology description

Staging date: DD/MM/YYYY *TNM staging:* T N M *Staging* *Grade*

Metastatic disease Lung Bone Liver *Date diagnosed* DD/MM/YYYY

Other please specify

Tumor marker information

Date *Description* *Marker* *Value*

Chronic conditions		Date diagnosed	Treatment		Date
Spread to adjacent organs			Irreversable inoporable damage to organ of origin or other vital organ		
Evidance of distant metastatic spread			Demonstrated 5 year survival rate for this cancer is greater than 10%		

Treatment history

Treatment cost N$* *Cycle cost N$

Treatment history	Start date	End date	Treatment	Intent	Completed	If no reason, why not	Concurrent with other treatment	Outcome
Surgical								
Radiation								
Chemo								
Hormonal								

Please provide hard copies of all invetigations and their results

Treatment

Start date	End date	Number of cycles	Treatment intent	Nappi Code	Nappi description	ProtocoL	Dose	Frequency per cycle	Quanity per cycle

Service fees

Start date	End date	Tarrif codes	Tarrif description	Quantity per cycle	Unit cost	Cost per cycle

Radiation

Professional provider *Practice no*

Contact person *Practice tel no* *Email:*

Technical provider *Practice no*

Contact person *Practice tel no* *Email:*

Brachy Hospital *Practice no* *Brachy Surgeon* *Pr no*

Contact person *Practice tel no* *Email:*

	Code	Frequancy	Quality	Professional Fee NAD	Technical Fee NAD	Total NAD
Planning CT						
Planning 1						
Planning 2						
Radiation 1						
Radiation 2						
Radiation 3						
Radiation 4						
Brachy 1						
Brachy 2						
Brachy 3						
Brachy 4						
Brachy 5						
Total						

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*