We're about you

tel 061 285 5400
email chroniccare@nhp.com.na
website www.nhp.com.na
Unit 2, Demushuwa Suites, C/o of Grove & Ombika Sts
Kleine Kuppe, Windhoek
PO Box 23064, Windhoek, Namibia
Reg No: MOHSS 003

Chronic Care form

Please note *In order for the administrator to deliver efficient service to you, it is imperative that all sections of this application form to be completed in full. Failing this may cause delay in the processing of the application.* ***Please submit this form to chroniccare@nhp.com.na.***

Section 1 Particulars of principal member (must be completed)

Membership number | Benefit option: Select a benefit | Dependant code

Title: Mrs | Initials | First name (s)

Surname

Date of birth | Gender: M F

Tel (h) | Tel (w)

Cell

Section 2 Particulars of patient (must be completed)

Title: Mrs | Initials | First name (s)

Surname

List of patient(s) allergies, other medical conditions suffered and any other treatment being received

Diagnosis and medicine(s) for which authorisation is requested (to be completed by doctor)

Diagnosis or ICD 10 code

Medicine trade name

Strength e.g. 10mg | Directions e.g. 1 tds

Special investigations/motivations

Repeats: Yes | No | Quantity

Diagnosis and medicine(s) for which authorisation is requested (to be completed by doctor) (continued)

Diagnosis or ICD 10 code

Medicine trade name

Strength e.g. 10mg *Directions e.g. 1 tds*

Special investigations/motivations

Repeats ☐ *Yes* ☐ *No* *Quantity*

Diagnosis or ICD 10 code

Medicine trade name

Strength e.g. 10mg *Directions e.g. 1 tds*

Special investigations/motivations

Repeats ☐ *Yes* ☐ *No* *Quantity*

Diagnosis or ICD 10 code

Medicine trade name

Strength e.g. 10mg *Directions e.g. 1 tds*

Special investigations/motivations

Repeats ☐ *Yes* ☐ *No* *Quantity*

Diagnosis or ICD 10 code

Medicine trade name

Strength e.g. 10mg *Directions e.g. 1 tds*

Special investigations/motivations

Repeats ☐ *Yes* ☐ *No* *Quantity*

Diagnosis or ICD 10 code

Medicine trade name

Strength e.g. 10mg *Directions e.g. 1 tds*

Special investigations/motivations

Repeats ☐ *Yes* ☐ *No* *Quantity*

Diagnosis or ICD 10 code

Medicine trade name

Strength e.g. 10mg *Directions e.g. 1 tds*

Special investigations/motivations

Repeats ☐ *Yes* ☐ *No* *Quantity*

Please note *Should you need additional space to provide additional information, please make a copy of this page and attach it to your application.*

Doctor acknowledgment and declaration

Title	Dr	*Initials*		*First name (s)*	
Surname					
Practice number					
Tel					
Email					
How many months/years has he/she been your patient?					

I, (the doctor), _____, herewith confirm that I have examined and/or procured the tests and/or diagnostic investigations referred to the patient/family. I certify that the particulars are to the best of my knowledge and belief, true and accurate. I acknowledge that the Fund and/or administrator will rely on such particulars when making any recommendations regarding the payment of ongoing/chronic medication.

_____
Signature of doctor

Date

Practice stamp

I/we authorise any doctor, hospital, clinic, laboratory and/or medical facility in possession of any medical information regarding myself, or any dependant (also newly born baby), to disclose any medical or historical information to the Fund and/or its administrator, provided such information is treated as confidential at all times. I agree that this authorisation request shall remain in force after my/their deaths. I indemnify the Fund and/or its administrator against any claim of whatsoever nature, which may be made against them as a result of or arising out of the disclosure of any test results or medical information. I/we warrant that the information in this application form is correct.

_____
Signature of principal member

_____
Date

Please note ***This form is to be submitted to chroniccare@nhp.com.na.***