We're about you

Chronic Lifestyle Extender benefit request

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

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.*

Section 1 Particulars of principal member (must be completed)

Membership number | Benefit option

Title | Initials | First name(s)

Surname

Date of birth (D D M M Y Y Y Y) | Gender (M F)

Tel (H) | Tel (W)

Cell | Fax

Section 2 Particulars of patient (if applicable)

Title | Initials | First name(s) | Dependant code

Surname

Section 3 Name of condition

Diabetes ☐ Type 1 ☐ Type 2

High blood pressure (Hypertension) ☐

Cholesterol ☐

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

Treatment on previous medical aid fund or diagnosis ☐ Yes ☐ No | If yes, name of medical aid fund

Diagnosis or ICD 10 code

Medicine trade name

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

Special investigations/motivations

Repeats ☐ Yes ☐ No | Quantity

Treatment on previous medical aid fund or diagnosis ☐ Yes ☐ No | If yes, name of medical aid fund

Diagnosis or ICD 10 code

Medicine trade name

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

Special investigations/motivations

Repeats ☐ Yes ☐ No | Quantity

Treatment on previous medical aid fund or diagnosis ☐ Yes ☐ No | If yes, name of medical aid fund

Diagnosis or ICD 10 code

Medicine trade name

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

Special investigations/motivations

Repeats ☐ Yes ☐ No | Quantity

Treatment on previous medical aid fund or diagnosis ☐ Yes ☐ No | If yes, name of medical aid fund

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 | Initials | First name(s)

Surname

Practice number

Tel (W) | Fax

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

D D M M 2 0 Y Y

Date

Practice stamp

Member acknowledgment and declaration

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

D D M M 2 0 Y Y

Date