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Hospital pre-authorisation 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

Particulars of patient (must be completed)

Membership number			Benefit option) Dependant code		
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							
Particulars of principal member (must be completed)							
Title	Initials	First name(s)					
Surname							
Particulars of patient (must be completed)							
Name of Hospital			Practice number				
Date of admission	D D M M 2	0 Y Y	ICD codes used				
Procedure codes							
Name of doctor/specialist			Practice number				
Preliminary diagnosis							
Treatment plan							

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.

