We're about you

Hospital pre-authorisation request

tel 061 285 5400
email cases@nhp.com.na
website www.nhp.com.na
Erf 1319, Grove Street
Kleine Kuppe, Windhoek
PO Box 23064, Windhoek, Namibia
Reg No: MOHSS 003

Particulars of patient (must be completed)

Membership number | Benefit option | Select a benefit

Title | Initials | First name(s)

Surname

Date of birth | 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 | 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.

Signature of principal member | Date