









Hospital pre-authorisation request

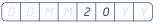
tel 061 285 5400 email cases@nhp.com.na website www.nhp.com.na Erf 1319, Grove Street Kleine Kuppe, Windhoek PO Box 23064, Windhoek, Namibia Reg No: MOHSS 003

Particulars of patient	t (must be completed)
Membership number	Benefit option
	nitials 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 princip	al member (must be completed)
Title II	nitials First name(s)
Surname	
Particulars of patient	t (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 acknowledg	ment 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

Signature of principal member

information in this application form is correct.



Date