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P.O. Box 97203
Windhoek

APPLICATION FOR CHRONIC MEDICATION BENEFIT

TO BE COMPLETED BY THE MEMBER

MEMBER DETAILS

MEMBERSHIP NUMBER

SURNAME

TITLE INITIAL/S

ADDRESS

TELEPHONE NUMBER (H) (W)

EMAIL ADDRESS CELLPHONE NUMBER

PATIENT DETAILS

SURNAME

NAME INITIAL/S

ADDRESS

TELEPHONE NUMBER (H) (W)

EMAIL ADDRESS

CELLPHONE NUMBER

I authorise my medical practitioner to furnish and/or disclose any fact relating to this application to the Managed Health Care Division, as well as any additional information that may be required from time to time.

MEMBER'S SIGNATURE DATE D D M M Y Y

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

DOCTOR DETAILS

SURNAME INITIAL/S

TELEPHONE NUMBER (W) FAX

POSTAL ADDRESS

EMAIL ADDRESS

CELLPHONE NO

DOCTOR'S PRACTICE NO SPECIALITY

PLEASE NOTE THE SPECIAL REQUIREMENTS FOR THE PRESCRIPTION OF THE FOLLOWING:

ROACCUTANE _____ DERMATOLOGICAL REPORT _____

LOCERYL, LAMISIL, etc. FOR FUNGAL INFECTION _____ PATHOLOGY REPORT

FOSAMAX, EVISTA, MIACALCIC, AREDIA, DECA-DURABOLIN _____

(INITIALLY) _____ BONE DENSITY REPORT

ENDOMETRIOSIS _____ GYNACOLOGICAL REPORT

LIPID DISORDER _____ FULL LIPOGRAM REPORT

PEPTIC ULCER DISEASE & GASTRITIS _____

(INITIALLY PLUS EVERY 2 YEARS _____ GASTROCOPY/& HP TEST RESULTS

GORD, HIATUS, HERNIA _____ GASTROCOPY

Copies of the results/reports must be attached to this Application Form

PATIENT DETAILS:

MEMBERSHIP NUMBER OF MAIN MEMBER

PATIENT NAME AND SURNAME

DATE OF BIRTH D D M M Y Y

WEIGHT ____ KG HEIGHT ____ CM BLOOD PRESSURE ____ / ____

SMOKING: ☐ NEVER ☐ EX-SMOKER ☐ <10 PER DAY ☐ >10 PER DAY

EXERCISE: ☐ NEVER ☐ < 1 HOUR PER WEEK ☐ 1-3 HOURS PER WEEK ☐ >3 PER WEEK

ALLERGIES: PENICILLIN ☐ ASPIRIN ☐ SULPHONAMIDES ☐ OTHER ☐

PREVIOUS HISTORY OF:

HEART DISEASE/HYPERTENSION YES NO Diabetes Mellitus YES NO ASTHMA YES NO

CHRONIC MEDICATION PRESCRIBED (please use block letters)

Chronic Condition and Date of Diagnosis	MEDICATION Prescribed (trade name or generic equivalent)	Strength (eg. 50mg)	Directions (eg. tds)	Date medication started	Type and date of investigation/ report

CHRONIC MEDICATION STOPPED (please use block letters)

Diagnosis	Medication (trade name or generic equivalent)	Strength (eg. 50mg)	Directions (eg. tds)	Date medication stopped

I hereby certify that the medical information provided on this application form is correct.

Signature of Medical Practitioner _____

Date D D M M Y Y