PSEMAS

APPLICATION FOR CHRONIC MEDICATION BENEFIT

Enquiries: Tel: +264 61 287 6175 • Fax: +264 61 287 6176 • P.O. Box 24792, Windhoek, Namibia

TO BE COMPLETED BY MEMBER

MEMBER DETAILS

MEMBERSHIP NUMBER

SURNAME

TITLE INITIAL/S

POSTAL ADDRESS

TELEPHONE (H) (W)

E-MAIL ADDRESS CELLPHONE No.

PATIENT DETAILS

DATE OF BIRTH D D M M Y Y Y Y

SURNAME

FIRST NAME TITLE

TELEPHONE (W) (H)

E-MAIL ADDRESS CELLPHONE No.

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 Y Y

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

DOCTOR DETAILS

SURNAME INITIAL/S

TELEPHONE (W) FAX

POSTAL ADDRESS POSTAL CODE

E-MAIL ADDRESS CELLPHONE No.

DOCTOR'S PRACTICE No. SPECIALITY

PATIENT DETAILS

MEMBERSHIP NUMBER OF MAIN MEMBER

PATIENT NAME AND SURNAME

DATE OF BIRTH D D M M Y Y Y Y GENDER M F

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 HOURS PER WEEK

ALLERGIES:

PREVIOUS HISTORY OF

HEART DISEASE/HYPERTENSION YES NO DIABETES MELLITUS YES NO ASTHMA YES NO

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

PrimeHealth Namibia (Pty) Ltd.

METHEALTH NAMIBIA ADMINISTRATORS

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 Y Y