REPUBLIC OF NAMIBIA

Pubic Service Employees
Medical Aid Scheme

Tel: 061-374150
Fax: 061-271222
088624543
088647663
088639841

METHEALTH NAMIBIA
ADMINISTRATORS

Please Note:
This auth is only valid for 30 days.

PSEMAS DEVIATION MATTER FORM

Request Date…………………………………..
Member Number …………………………………………….. …………….. Main Member ……………………………………
Deviation for Main Member / Dependant………………………… DOB …………………………………………………..

Standard Option ☐ Higher Option ☐
Complimed Member Yes/No …………………………… Complimed Number……………………………..

A. DEVIATION FOR PRIVATE HOSPITALISATION

Name of Hospital…………………………………………………………… Practice Number …………………………………………………
Diagnosis / Proposed Treatment ………
………

First Pre-auth ☐ Extended Stay ☐ Review ☐

Private Hospital 95% of Namaf Tarrif ☐ Days Approved ☐

OR
State Hospital A ☐ B ☐ C ☐ Days Approved ☐

B. ADDITIONAL PRE-AUTHORISATION (Please mark with X requested item)

1. **Medicine** 92.5% (Excluded drug, High cost drug, Specialized drug, Major Illness drug)

Approved ☐ Declined ☐

Detail:……
……….

2. **Internal Prosthesis / External Appliances**

Approved ☐ Declined ☐

Details:………
……..

3. **Procedures / Treatment** (Excluded procedure, new technology, high cost procedure, nursing care, etc)

Approved ☐ Declined ☐

Details:………
……..………

4. Travelling Costs

Economy Air Ticket ☐ Fuel (Own Transport) ☐ N$2.60/km ☐ Bus Ticket ☐

Approved ☐ Declined ☐

Details:……

……..

5. Accommodation

(Note: Benefit available only on a registered B & B, Guesthouse or Lodge and upon submission of receipt)

Approved ☐ Declined ☐

Within Borders of Namibia (N$450 per day per family) ☐

OR

Outside the Borders of Namibia (N$600 per day per family) ☐

Details:……
……..

6. Non-Emergency Ambulance Services

Mercy Flight ☐ Inter-hospital Transfer ☐

Approved ☐ Declined ☐

Details:……
……

C. REQUEST FOR FINANCIAL ASSISTANCE

1. Request for Advance Payment

(Note: Applicable only to non-contracted in Health Care Providers and RSA Health Care Providers)

Approved ☐ Declined ☐

PSEMAS Tariff 95% of the Total Cost ☐ 100% of the Total Cost ☐

Details:……
…….................

2. Request to Pay Excess of PSEMAS Tariffs

(Note: Not applicable to contracted-in Health Care Providers. Contracted-in Health Care Providers must charge only the PSEMAS Tariffs)

Approved ☐ Declined ☐

95% of the Total Cost ☐ 100% of the Total Cost ☐

Details:……
……

3. Request for Stale Claim Approval

Approved ☐ Declined ☐

Details:……
……...............

For Official Use Only:

RECOMMENDATION DONE BY ADMINISTRATOR:

NAME (PRINT)…………………………………………………………………

JOB TITLE……………………………………………………………………

DATE……………………………………………………………………………SIGNATURE …………………………………………………

APPROVAL BY MEDICAL ADVISOR:

Approved Administrator Recommendation ☐ Declined Administrator Recommendation ☐

Reason if Declined:………………………………………………………………………………...

NAME(PRINT)…………………………………………………………

DATE..SIGNATURE...

APPROVAL BY PUBLIC SERVICE COMMISSION:

Approved Administrator Recommendation ☐ Declined Administrator Recommendation ☐

Reason if Declined:………………………………………………………………………………...

NAME (PRINT)……………………………………………………………

DATE…………………………………………………………………………SIGNATURE…………………………………………………..