Return to:
Chronic Medication Utilisation Department
Namibia Medical Care
PO Box 24792
WINDHOEK, NAMIBIA

NMC
NAMIBIA MEDICAL CARE

Enquiries
Tell. (061) 287 6171/287 6175
Fax (061) 287 6176

APPLICATION FOR CHRONIC MEDICATION BENEFITS

A. *(To be completed by Member)*
1. DETAILS OF MEMBER

Surname

Title | Initial/s | Date of Birth

Postal Address

Postal Code

Telephone No. (h) | Telephone No. (w)

Fax No.

Membership Number

Current Option

OPAL		RUBY		SAPPHIRE		DIAMOND		EMERALD		AMBER	

(Indicate with an X)

2. DETAILS OF APPLICANT *(i.e. the dependant/patient)*

Surname

Title | Initial/s | Date of birth

I authorise the 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.

I hereby certify that the information provided on this Application Form is correct and understand the terms of this Application. I also understand that my/my dependant's participation is subject to my/my dependant's eligibility under the Medical Aid Fund. I agree that my/my dependant's condition may be subject to disease management interventions.

Signature of Member | Date

B. *(To be completed by the attending medical practitioner)*
3. DETAILS OF MEDICAL PRACTITIONER

Surname | Initial/s

Postal Address

Postal Code

Telephone No. | Fax

Cellphone No.

E-mail Address

Qualifications | Practice No.

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

Fosamax, Evista, Miacalcic, Aredia, Deca-Durabolin (initially)
Lipid disorders
Peptic ulcer disease & gastritis (initially plus every 2 years)
GORD, Hiatus hernia
Bone density report
Full lipogram result
Gastroscopy/BA swallow & HP test result
Gastroscopy/BA swallow

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

4. PATIENT DETAILS

MEMBERSHIP NUMBER OF MAIN MEMBER

PATIENT NAME AND SURNAME DATE OF BIRTH

MALE FEMALE 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 >3HOURS PER WEEK

ALLERGIES: PENICILLIN ASPIRIN SULPHONAMIDES OTHER

5. CHRONIC MEDICATION PRESCRIBED:

Chronic condition and date of diagnosis	**Medication prescribed (trade name of generic equivalent)**	**Strength** (eg. 50mg)	**Direction** (eg. tds)	**Date medication started**	**Type and date of investigation/report**

May a less-expensive generic equivalent be used? Yes No

6. CHRONIC MEDICATION STOPPED:

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

Patient History	**Description**	**Family History**
Yes No	Heart Disease	Yes No
Yes No	Previous M yocardial Infarction	Yes No
Yes No	Other Major Ailments	Yes No

Please Specify Ailments _____

I hereby certify that the medical information provided on this Application Form is correct.

Signature of Medical Practitioner

Date