Return to:
Chronic Medication Utilisation Department
Namibia Medical Care
P.O. Box 24792
Windhoek, Namibia

NMC
NAMIBIA MEDICAL CARE

Enquiries
Tel. (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 (Prof/Dr./Mr./Mrs. etc.) | Initial/s | Date of Birth (D D M M Y Y)

Postal Address

Postal Code

Tel. (Home) | Tel. (Work)

Cell No. | Fax:

Membership Number

Current Option

Topaz	Topaz Plus	Opal	Jade	Ruby	Sapphire	Diamond
Emerald	Emerald Plus	Amber	Amber Plus			

(Indicate with an X)

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

Surname

Title (Prof/Dr./Mr./Mrs. etc.) | Initial/s | Date of Birth (D D M M Y Y)

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 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 Fund. I agree that my/my dependant's condition may be subject to disease management interventions.

Member's Signature _____ Date (D D M M Y Y)

3. DETAILS OF MEDICAL PRACTITIONER

Surname

Postal Address

Postal Code

Tel. | Fax.

Cell No. | Email

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

Main Member's Membership No.

Patient's Name and Surname D.O.B D D M M 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: Penicillin ASPIRIN Sulphonamides Other

5. PRESCRIBED CHRONIC MEDICATION:

Chronic Condition and Date of Diagnosis	Medication Prescribed (Trade Name of Generic Equivalent)	Strength (e.g. 50mg)	Direction (e.g. tds)	Date Medication Started	Type and Date of Investigation/Report

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

6. DISCONTINUED CHRONIC MEDICATION:

Diagnosis	Medication Prescribed (Trade Name of Generic Equivalent)	Strength (e.g. 50mg)	Direction (e.g. tds)	Date Medication Started

Patient History				Description	Family History			
Yes		No		Heart Disease	Yes		No	
Yes		No		Previous Myocardial 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.

Medical Practitioner's Signature _____ Date D D M M Y Y