

CHRONIC MEDICATION BENEFIT APPLICATION FORM

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Please Note: Only Fully Completed Forms will be processed

NAPOTEL

MEDICAL AID FUND



Section A - Principal Member Details: (not the patient's details)

Surname: _____ Title: _____

First Names: _____ Membership Number: _____

Postal Address: _____

Telephone Number: Home: _____ Work: _____

Cell: _____

Section B - Patient's Details:

Surname: _____ Title: _____

First Names: _____

Date of birth: _____ Dependant code: _____

Tel: _____ Fax: _____

Section C - Patient Consent: (To be completed by patient)

I hereby give my written consent to the applicable treating doctor to state the diagnosis and details of my condition on the application form and that this information will remain confidential upon submission to the Medical Aid Fund.

Patient signature: _____ Date: _____

Section D - Pharmacy Details:

Pharmacy Name: _____ Practice No.: _____

Tel: _____ Fax: _____

Section E - Treating Medical Practitioner's Details:

Doctor's Initials and Surname: _____ Speciality: _____

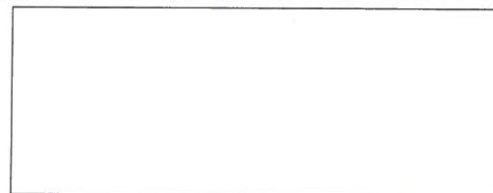
Practice Number: _____

Telephone Number: _____ Fax Number: _____

Postal Address: _____

Signature: _____

Date: _____



Practice Stamp

Administered by  Prosperity Health

