

CHRONIC MEDICATION BENEFIT REGISTRATION FORM

Tel.: +264 61 2999 000 • Fax: +264 61 2999 112



Renaissance Health
Medical Aid Fund

Please Note: Only Fully Completed Forms will be processed

Section A - Chronic Benefit Builder:

CHRONIC MEDICATION PLAN FOR WHICH REGISTERED (*mark with X*)

BASIC PLAN

Annual Benefit N\$6 000

STANDARD PLAN

Annual Benefit N\$12 000

EXECUTIVE PLAN

Annual Benefit N\$24 000

DAY TO DAY CHRONIC BENEFIT

Inclusive

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

Surname: _____ Title: _____

First Names: _____ Membership Number: _____

Postal Address: _____

Telephone Number: Home: _____ Work: _____

Cell: _____

Section C - Patient's Details:

Surname: _____ Title: _____

First Names: _____

Date of birth: _____ Dependant code: _____

Tel: _____ Fax: _____

Section D - 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 E - Company Authorisation:

Company Name: _____

CB Number: _____

Print Name: _____

Signature: _____

Date: _____

Stamp

Administered by  Prosperity Health

Section F - Pharmacy Details:

Pharmacy Name: _____ Practice No.: _____

Tel: _____ Fax: _____

Section G - Treating Medical Practitioner's Details:

Doctor's Initials and Surname: _____ Speciality: _____

Practice Number: _____

Telephone Number: _____ Fax Number: _____

Postal Address: _____

Signature: _____

Date: _____

--

Practice Stamp

Section H - Medication Details: (to be completed by attending Medical Practitioner)

Diagnosis / Chronic Conditions	New / Add on	Discontinued	Medicine and Strength	Dosage	Quantity	No. of Repeats

Section I - Where appropriate - Generic Equivalents may be supplied:

(To be completed by attending Doctor)

Yes No **Section J - Special Requirements for Prescriptions:** (only if the following meds/diagnosis are applicable)

Report / Tests Required	Tests Date / Results	Medication / Diagnosis
Bone Density Report		Fosamax, Evista, Miacalcic, Aredia, Deca-Durabolin
Total cholesterol Full Lipogram (>5)		Lipid Disorders
Gastroscopy + HP test result		Peptic ulcer disease + gastritis
Gastroscopy		GORD, Hiatus Hernia, Syndrome X

Patient's Particulars:Age

Does the patient smoke

Member No.: Yes No Mass (kg)

Gender

Male Female **Family History (Applicable to condition)**

Please note: Copies of all tests / reports must be attached to this Application Form