CHRONIC MEDICATION APPLICATION FORM

CONFIDENTIAL

AFA
Associated Fund Administrators
people.passion.solutions.

Administered by Associated Fund Administrators Botswana (Pty) Ltd
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MANAGED CARE DEPARTMENT: WhatsApp: +267 77091192 I **E-mail:** managedcaredepartment@afa.co.bw

IMPORTANT: Please note that all reasonable steps will be taken to maintain patient confidentiality
TO BE COMPLETED BY THE APPLICANT

PRINCIPAL MEMBER DETAILS:

Member's First name: Surname: Title: Mr ☐ Mrs ☐ Ms ☐

Medical Scheme: Option:

Member's number: I.D Number:

PATIENT DETAILS:

First Name: Surname: Title: Mr ☐ Mrs ☐ Ms ☐

I.D. Number: Date of birth:

Telephone Number (H): Telephone Number (W):

Postal Address: Beneficiary: Member ☐ Spouse ☐ Child ☐

To keep my correspondence confidential, post my letters to:

BUDDY DETAILS

Name of Buddy Telephone

Relationship Cellphone number

MEDICINE SUPPLIER (i.e. Pharmacy or Dispensing Doctor)

Doctor's surname: First Name: Med Aid Practice Number

Postal address: Fax Number:

Telephone Number: E-mail address:

I/we understand that all personal clinical information supplied to the Managed Care Programme (MCP) will be used to determine access to the Chronic Medicine Benefit for reimbursement of essential medication. The programme's medical staff will review this information in order to make informed recommendations regarding the provision of these benefits. Your doctor, however, retains responsibility for your care, irrespective of the benefits authorised.

I/we therefore, authorise any doctor, hospital, clinic, laboratory and/or medical facility in possession of any medical information regarding myself, the applicant or any dependent, to provide the MCP with information that it may require. I/we warrant that the information contained in this application form is correct.

MEMBER'S SIGNATURE

PATIENT'S SIGNATURE Date:
(Not required if patient is a minor)

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

DETAILS OF THE DOCTOR WHO WILL BE PROVIDING ONGOING CARE:

Doctor's surname: First Name: Med Aid Practice Number

Postal address: Fax Number: Botswana Health Prof Council Reg Number:

Telephone Number: E-mail address: Qualifying Degree:

1. **CLINICAL DATA**

1.1 Male ☐ Female ☐ Weight: Kg and Height (if child): cm

1.2 Blood pressure mm Hg Blood sugar mmol/L (if applicable)

2 RISK FACTORS

2.1 Family history of (any) other major disease Y ☐ N ☐

2.2 Specify:

3 ALLERGIES:

Penicillin ☐ Sulfonamides ☐ Other None ☐

3.1 Specify (if other)

4 MEDICAL HISTORY

History

DIAGNOSIS	MEDICATION	Strength (e.g. 10mg)	Directions (e.g 1 tds)	Period in use (months)	Period required? (months)
Condition 1					
Condition 2					
Condition 3					
MOTIVATIONS in respect of drugs as requested above. (e.g. For non-generic substitution)	Medicine Trade Name	Motivation(s)			

N.B: Generic equivalents will be approved unless otherwise stated.

ACKNOWLEDGEMENT BY EXAMINING DOCTOR:

I certify that the above particulars are, to the best of my knowledge and believe, true and accurate, having conducted a personal examination and procured the tests and/or other diagnostic investigations referred to. I acknowledge that the MCP will rely on such particulars when making any recommendation regarding payment for treatment to PULA & BPOMAS.

This refers specifically to patient: First Name Surname

DOCTOR'S SIGNATURE:

Please fax completed form to: 3935 281