Pula Medical Aid Fund

Please complete in BLACK ink
Print clearly using CAPITAL letters
Only one character per block
Leave one block between words
Mark with an [X] where necessary

Administered by AFA Botswana (Pty) Ltd.

AFA House
Plot 61918, Showgrounds
Office Park
P O Box 1212, Gaborone
Tel: 365 0500/365 0586

Plot 31966, Unit 2
Ground Floor
Baines Avenue
P O Box 323, Francistown
Tel: 241 2290/241 2390

www.pulamed.co.bw

TEMPORARY FAMILY / PRIMARY CARE FACILITY or DOCTOR

REGISTRATION FORM – CONFIDENTIAL

IMPORTANT: This form is to be used only in cases where the registered beneficiary (principal member or dependants) will be far away from his/her normal primary care provider for a period exceeding three (3) months but not more than 6 months, and is thus selecting a facility/doctor nearest to him/her for the time being as a temporary primary care provider.

1. PRINCIPAL MEMBER DETAILS:

Principal Member's First name:	Surname:	Tittle:
Principal Member's number:	Benefit Option:	
Medical Scheme:		

2. REGISTERED DEPENDANTS DETAILS: (To be completed for affected beneficiary(s) only)

First Name:	Surname:	Tittle:
First Name:	Surname:	Title
First Name:	Surname:	Title
First Name:	Surname:	Title:
First Name:	Surname:	Title:

3. PRINCIPAL MEMBER'S CONTACT DETAILS: (To be completed if different from one previously submitted to the Scheme/AFA)

Home address? _____

Work address? _____

Telephone? (W) _____. Telephone? (H) _____ E-mail? _____

4. MY / THE FAMILY TEMPORARY PRIMARY CARE FACILITY'S / DOCTOR'S NAME AND PRACTICE NUMBER DETAILS ARE AS BELOW

Name of Doctor / Facility	Practice Number & Postal Address	Telephone:	Fax
	Practice No.		
	Postal Address:	E-mail address:	

4.1 Reason and Duration of temporary registration (* = Delete as appropriate): Start date: / / 200 End date: / / 200

Away for > 3months but< 6months* / Temporary Transfer for > 3months but< 6months* / On official trip for > 3months but< 6months*

Other: _____

5. ACCEPTANCE OF MEMBER / DEPENDANT(S) FOR TEMPORARY PRIMARY CARE SERVICES

I Dr _____, have accepted the above named person(s) for temporary primary care services in my practice.

Signature: _____ Official Date Stamp

I Dr / Mr / Ms _____, being duly authorised to do so, have accepted the above named person(s) for temporary primary care services on behalf of the facility/doctor named in (4) above.

Signature: _____ Official Date Stamp:

Member's / Beneficiary's Signature: _____ Date _____

NB: This form must be completed and sent to AFA together with claims, to ensure appropriate payment.

PLEASE FAX COMPLETED FORM TO: (267) 3951165