BOTSWANA PUBLIC OFFICERS' MEDICAL AID SCHEME
Administered by Associated Fund Administrators Botswana (Pty) Ltd.

Full member of the International federation of health plans

AFA House Plot 61918 • Showgrounds Office Park • P.O. Box 1212 Gaborone • Botswana • Tel: (+267) 365 0500 • Fax: (+267) 395 1165

CHANGE OF 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) wishes to change his/her primary care provider for whatsoever reason, and selects a new facility/doctor to provide primary care services to him/her or his/her dependants.

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 NEW 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 Date of change of primary care provider: (* = Delete as appropriate): **Start / Effective Date:** / / **200**

Moving away from current location* / Not happy with service* / Personal reasons* / ……..*

Other: _____

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

I Dr _____, have accepted the above named person(s) for 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 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 prior to submission of claims, to ensure appropriate payment.**

PLEASE FAX COMPLETED FORM TO: (267) 3951165