# CHRONIC MEDICATION APPLICATION FORM


ADMINISTRATORS OFFICE GABORONE
Plot 54349, Ground Floor, West Wing, The Field Precinct, CBD
Premium Box 625 AAH, Gaborone
Tel: +267 316 8900
Fax: +267 316 8910

ADMINISTRATORS OFFICE FRANCISTOWN
Plot 32397, Office 26, Sunshine Plaza
Tel: +267 316 8902
Fax: +267 316 8910

**IMPORTANT: Please note that all reasonable steps will be taken to maintain patient confidentiality**

**To be completed by the Principal Member/Applicant**

## SECTION 1: PRINCIPAL MEMBER DETAILS

| | | |
|---|---|---|
| First Name: | Surname: | Title: |
| Benefit Option: | Membership Number: | I.D. Number: |
| Email: | Tel (H/W): | Mobile: |

Postal Address: .................................... Residential Address: ....................................

## SECTION 2: PATIENT DETAILS

| | | |
|---|---|---|
| First Name: | Surname: | Title: |
| I.D. Number: | Date of Birth: | Beneficiary: Member/Spouse/ Child |
| Email: | Tel (H/W): | Mobile: |

**How would you like us to communicate confidentially with you?**

SMS: ☐ Email: ☐ Postal: ☐ Your Doctor: ☐

OTHER DOCTORS OR SPECIALISTS that you are seeing in addition to the Doctor filling in this form:

| Name of Doctor | Specialty | Telephone | Fax |
|---|---|---|---|
| | | | |
| | | | |

## SECTION 3: MEMBER/PATIENT DECLARATION

I hereby declare that the information furnished in this application is true and correct to the best of my knowledge. I believe and I undertake to inform the Scheme of any changes herein.

MEMBER/PATIENT SIGNATURE:.................................... DATE:....................................

**To Be Completed By The Attending Medical Practitioner**

## SECTION 4: DETAILS OF THE DOCTOR WHO WILL BE PROVIDING ONGOING CARE

| | | |
|---|---|---|
| Doctor's Surname: | First Name: | Qualifying Degree: |

| | |
|---|---|
| Practice Number: | Botswana Health Prof Council Reg Number: |
| Postal Address: | |
| Telephone Number: | Fax Number: |
| E-mail Address: | |

## SECTION 5: GENERAL INFORMATION

**1 CLINICAL EXAMINATION:**

Male ☐ Female ☐ Weight ☐ Kg Height ☐ cm

Blood pressure ☐ / ☐ mm Hg. Blood sugar ☐

**2 RISK FACTORS:**

Family history of (any) other major disease Yes ☐ No ☐

Specify:....................................

**3 ALLERGIES:** Penicillin ☐ Sulfonamides ☐ Other ☐ None ☐

Specify (If other):....................................

## SECTION 6: CONDITIONS AND MEDICATIONS FOR WHICH THIS APPLICATION IS BEING MADE

| 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) |
|---|---|---|
| | | |
| | | |
| | | |

***Generic equivalents will be approved unless otherwise contraindicated and/or stated**

## SECTION 7: ACKNOWLEDGEMENT BY TREATING DOCTOR:

Following clinical examinationabd review of results of diagnostic tests/investigations referred to above, I cerify that the above information is to the best of my knowledge, true and accurate.

DOCTOR'S SIGNATURE:.................................... DATE:....................................

## SECTION 8: CONSENT TO RECEIVE SCHEME UPDATES & MARKETING MATERIAL

I consent to receive Scheme updates and Marketing BPOMAS products, benefits, promotions and rewards. This can be perfomed through:

Email ☐ SMS ☐ Phone ☐ Postal Adress ☐

MEMBER/PATIENT SIGNATURE:.................................... Date:....................................

## SECTION 9: BPOMAS DATA PROTECTION AND PRIVACY STATEMENT

Data protection is a matter of trust and your trust is important to us. We respect your right to confidentiality and privacy and, we are committed to complying with the Data Protection Act. The protection and the lawful collection, processing and use of your personal data is therefore an important concern for us in the provision of our services to our members.

## SECTION 10: ACKNOLEDGEMENT AND CONSENT BY MEMBER

### 10.1 Acknowledgement

I hereby expressly acknowledge that the processing off my Personal Information and/or Special Personal Informantion by BPOMAS ("collectively referred to as "Personal Information"), as defined in terms of the Data Protection Act of 2018 (DPA). I acknowledge that;

10.1.1 I have read and understood the provisions of BPOMAS's Data Protection and Privacy Statement, thereby fully appreciating the manner in which BPOMAS may process my Personal Information and for which purpose(s) BPOMAS may process such Personal Information.

10.1.2. Through submitting this application, I am providing BPOMAS with my Personal Information and that engaging with BPOMAS through any physical and/or electronic means, BPOMAS will in effect be processing the Personal Information provided by me from time to time.

10.1.3 BPOMAS may from time to time, depending on the circumstances, collect my Personal Information from another source other than myself.

10.1.4 I fully appreciate that BPOMAS will only process my Personal Information in a manner consistent with the provisions of its Data Protection Act, as well as for the purpose(s) set forth therein.

10.1.5 In accordance with the provisions of Section 28 of DPA, I have been provided with adequate notification of the processing of my Personal Information by BPOMAS, the scope and purpose(s) for such processing, as well as my rights to object to such processing should I elect to do so, and to request for access/destruction of my Personal Information that is held by BPOMAS.

10.1.6 I acknowledge that the processing of my Personal Information is a mandatory requirement for the existence of a valid medical aid.

10.1.7 I have read and understood the undertakings made by BPOMAS in its Data Protection and Statement to the effect that it will ensure that any and all of personal Information shall be processed with a reasonable standard of care as may be expected from BPOMAS.

### 10.2 Consent

In light of the above acknowledgements, and in accordance with the requirements set forth in Section 20 of Data Protection Act, I hereby provide my specific and informed consent to BPOMAS for the processing of my Personal Information for any purpose(s) legitimately connected or related to my application for membership, which purpose(s) may include, but not be limited to the following:

10.2.1 To provide or manage any information, products and/or services requested by me pursuant to my application for membership.

10.2.2 To establish my needs, requirements and preferences in relation to the products and/or services provided by the BPOMAS.

10.2.3 To facilitate the delivery of products and/or services to me as a member of BPOMAS to administer my claims and premiums.

10.2.4 To activate my medical aid and/or prescribed benefits to allocate a unique identifier (membership number) to me for the purpose of securely storing, retaining, and recalling my Personal Information from time to time, including after my membership is terminated.

10.2.5 To transact with suppliers and business partners, including healthcare service providers, network hospitals, pharmacies and relevant regulatory authorities to facilitate the delivery of products and/or services to me.

10.2.6 To provide me with health and wellness information throughout the subsistence of my membership.

10.2.7 To transact with third parties and transfer my Personal Information (locally or across border) to such third parties for the purpose of enabling BPOMAS to fulfil its legitimate pursuit of contractual obligations towards me and within the requirements of the Data Protection Act.

10.2.8 To analyse and profile my Personal Information collected for research and statistical purposes.

10.2.9 For general administration purposes pertaining to my membership.

MEMBER/PATIENT SIGNATURE.................................................................. DATE:..................................................................

# MANAGED CARE FORM 2