MANAGED CARE DEPARTMENT
Tel: 3933810 / 3951166: Fax: 3935281 / 3951165
MCD APPLICATION FORM - CONFIDENTIAL

CHRONIC MEDICATION APPLICATION FORM

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

PRINCIPAL MEMBER DETAILS:

Member's First name:	Surname:	Tittle:
Medical Scheme:		Option / Plan:
Member's number:	ID number:	

PATIENT DETAILS:

First Name:	Surname:	Tittle:
I.D. Number:	Date of birth:	Beneficiary Code:
Telephone Number (H):	Telephone Number (W):	
Postal Address:		

To keep your correspondence confidential, should we post your letters to your:

☐ Home address? ……

☐ Work address? ……

☐ 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

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

NAME and ADDRESS	TELEPHONE	FAX	E-MAIL

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 require 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:	Qualifying Degree:
Practice Number:	Botswana Health Prof Council Reg Number:	
Postal address:		
Telephone Number:	Fax Number:	
E-mail address:		

1 CLINICAL EXAMINATION (General information)

1.1 Male ☐ Female ☐ Weight ☐ Kg Height ☐ 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:……
……
……
……

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)

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: …… Date:……

Please fax completed form to: 3935 281 0r 3951 165