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

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

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

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FAMILY / PRIMARY CARE FACILITY or DOCTOR

REGISTRATION FORM – CONFIDENTIAL

IMPORTANT: **Please SELECT THE DOCTOR WHO REGURLARLY ATTENDS TO YOUR HEALTHCARE NEEDS.**
Where possible, select the Doctor who you and your dependants have easy access to.

1. PRINCIPAL MEMBER DETAILS:

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

2. REGISTERED DEPENDANTS DETAILS:

First Name:	Surname:	Using same Doctor		Tittle:
		Yes	No	
First Name:	Surname:			Title
First Name:	Surname:			Title
First Name:	Surname:			Title:
First Name:	Surname:			Title:

3. PRINCIPAL MEMBER'S CONTACT DETAILS:

Home address? _____

Work address? _____

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

4. MY / THE FAMILY 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:	

5. ACCEPTANCE OF MEMBER AND DEPENDANTS 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:

I/we understand that the doctor / facility I/we have selected (above) shall be responsible for all our/my primary healthcare needs, and that referral to other specialized or higher care facilities and doctors may only be done by the above named facility / doctor as appropriate. I also understand that I and my registered dependants may access any doctor or health facility in cases of emergency and/ or when our family primary care facility / doctor is not available.

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

NB: Where a family has to have more than one (1) Primary Care Facility / Doctor, one (1) form must be completed per facility / doctor. Each facility / doctor must sign the form to show acceptance to provide primary care service to the beneficiary(s).

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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.**

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