Once filled in please email the completed form and supporting documents to managedcare@bomaid.co.bw OR fax to +267 3184152/ 230 OR drop off at your nearest Bomaid office

Bomaid
Health & Happiness at heart

Chronic Ailment Form

A. YOUR DETAILS OF COVER - Level of cover (Please tick one box only)

A Standard ◯ A ◯ A Plus ◯ B ◯ B Plus ◯ C ◯ C Plus ◯ ISS ◯

B. PRINCIPAL MEMBER DETAILS - to be completed by the principal member

First Name (s)																										
Surname																										
Medical Aid Number										Date of Birth	D	D	M	M	Y	Y	Y	Y	Male / Female (Please tick where applicable)			M ◯		F ◯	
ID/ Passport No.									Nationality																	
Postal Address																										
Home Phone										Cellphone 1																
Work Phone										Cellphone 2																
Email Address 1																										
Email Address 2																										
Employer Name																										

C. PATIENT DETAILS - Please provide details of the patient who requires the medication

First Name (s)																										
Surname																			Male / Female (Please tick where applicable)			M ◯		F ◯		
Dependent Code			Date of Birth	D	D	M	M	Y	Y	Y	Y	Contact Number														

I hereby give consent that this application for chronic medication be given to BOMAID to perform drug utilisation review (DUR) if this service is provided for the sole purpose of enhancing my medical benefit. I understand that BOMAID needs to access personal clinical information in order to make informed recommendations regarding my chronic medication. I therefore authorise any medical service provider in possession of any medical information regarding myself or any of my dependants to provide BOMAID sufficient information that they may require, excluding any information which i stipulate in writing to my medical service provider. I acknowledge that my medical service provider retains responsibility for my treatment and diagnosis.

I hereby certify that the information provided on this application form is correct and I understand the terms of this application. I also understand that my participation is subject to my eligibility under the Medical Society.

Generic medication can significantly reduce prescription costs, while proviiding similar medical effect. Should there be a equivalent available (after agreement with yourDoctor) would you be prepared to use generic product?

Yes ◯ No ◯

Principal Member's Signature		Date signed	D	D	M	M	Y	Y	Y	Y

D. MEDICAL PRACTITIONER'S DETAILS - To be completed by the attending Medical Practitioner

Full Name(s)	
Postal Address	
Work Phone	Mobile No
Fax Number	Botswana Practice Number
Speciality	

E. CONDITION AND MEDICATION DETAILS - To be completed by the attending Medical Practitioner (One form per patient)

Attach copy of prescription. Application will NOT be processed without copy of prescription

First Name(s)	
Surname	

Chronic Condition	ICD 10 Codes	Medication prescribed (State strength, dosage & quantity)	Allergies	How long has this member been on this medication?		How many repeat prescriptions would you like your patient to receive (months)				
				Years	Months	3	6	9	12	Other
1.										
2.										
3.										

F. CLINICAL INFORMATION - To be completed by the attending Medical Practitioner

General

Weight				kg					cm
Blood Pressure				/					mm/Hg
Smoker?	Yes		No		Ave. sticks per day				
Stress Level	Mild		Moderate		Severe				
Exercise	Mild		Moderate		Vigorous				

Please specify type of exercise

Description	Patient History				Family History			
Heart Disease	Yes		No		Yes		No	
Previous Myocardial Infarction	Yes		No		Yes		No	
Other major ailments	Yes		No		Yes		No	

Please specify other ailments

If generic equivalent exists for products prescribed, may suitable generics be used for this patient?
(Please indicate with an X)

Yes ◯ No ◯

Medical Practioner's Signature		Date signed	D	D	M	M	Y	Y	Y	Y