PROMED CHRONIC MEDICINE APPLICATION FORM

Patient's Details	First name …… Middle name……Family Name/Last name…… Date of birth……/……/……. Age……. Sex……. Cell…… Email……
Membership Details	Policy number…… Membership number ……
Principal Member	First name …… Middle name……Family name/Last name…… Cell…… Email…… Employer……

Provider Details	Hospital Name…… Address …… Phone…… Doctor's first name …… Surname …… Speciality…….. Practice no.

To be completed by treating Doctor in Block letters

TESTS DONE	DATE OF TEST
…….	……
……..	……
…….	……

Doctor's comments

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PRUDENTIAL

Diagnosis/ICD 9/ICD 10 CODE	MEDICINE TRADE NAME	ACTIVE INGREDIENT	STRENGTH (e.g. 10mg)	Directions (e.g. 1 tab TDS

Doctor's declaration

I certify that the particulars are, to the best of my knowledge and belief, true and accurate. I acknowledge that the Insurer will rely on such particulars when making any recommendations regarding the payment of treatment and services.

DR'S SIGNATURE…… DATE…….

I hereby declare that the information in this form is true and correct. I am aware that the Insurer may request medical information from any medical facility, laboratory, clinic, hospital, doctor or specialist that it requires. In order to fully assess this application for benefits, I hereby give my consent for the Insurer to obtain this information. I understand that this application is subject to the **Promed** Health insurance Policy Conditions and benefits.

PATIENT/GUARDIAN SIGNATURE…… DATE……..