Renal Programme Application Form

Instructions

1. Complete this application form to register for chronic benefits for the first time or to register an additional chronic condition.
2. Please write in legible capitals and indicate your choice by making a tick (✓) in the appropriate spaces.
3. Complete one application form for each patient requiring chronic benefits.
4. The principal member or patient must complete.
5. If the appropriate sections are not completed, we will not be able to process your application.
6. Attach copies of any reports to support diagnosis of chronic condition, where applicable.
7. Please e-mail the completed and signed application forms to *preauthorization@metropolitan.co.bw*

Principal Member Information

Name(s): Surname:

Membership Number: Option:

Patient Information

Name(s): Surname:

Date of Birth: Dependant Code Gender: Male Female

Postal Address:

Contact Numbers: Home Work: Cell Phone:

E-mail Address:

Next of Kin: Next of Kin Cellphone:

Please indicate the method whereby you would prefer to receive your letter of authorisation:

Post E-mail Provider

I hereby give permission for my doctor to provide **Botsogo Health Plan** with my diagnosis and other relevant clinical information required. I understand that funding from the Chronic benefit is subject to clinical entry criteria and drug utilisation review as determined by the **Botsogo Health Plan** Disease Management Programme. By registering for the **Botsogo Health Plan** Disease Management Programme, I am aware that my condition may be subject to periodic review and that this may include access to my medical records and disclosure of general and medical information supplied to **Botsogo Health Plan.**

Generic medication or therapeutic alternatives can significantly reduce prescription costs. Should a generic equivalent be available, this will be authorised in place of your prescribed medication unless your doctor has specified otherwise.

If your application to the **Botsogo Health Plan** Disease Management Programme is declined, the relevant medication can be regarded as acute medication, subject to **Botsogo Health Plan** Rules and availability of funds.

Patient Signature: Date:

Medical Practitioner Details

Name(s): Surname:

Type of Practitioner (e.g. general practitioner):

Practice No: Tel No:

E-mail Address: Cellphone:

Medical Practioner Signature:

Date:

DIAGNOSIS & DEVELOPMENT of CHRONIC RENAL DISEASE

Primary cause (disease) of the failure:

Describe clinical course and degree of severity with special reference to diabetes, Include: radiological, laboratory tests done and copy tests to Momentum Africa – eg: CT scans, angiography digital vascular imaging should be done if indicated: current biochemical data should include FBC, U & E creatinine clearance, liver function, hepatitis screen, HIV

Status:

Present Health Status:

Presence / Absence of other disease processes:

DOES YOUR PATIENT HAVE ANY OF THE FOLLOWING CONDITIONS?

TICK THE APPROPRIATE BOX (✓)	YES	NO
Ischaemic Heart Disease		
Cerebro-Vascular Disease		
Chronic Liver Disease		
Chronic Lung Disease		
Malignancy		
Any other condition which could disadvantage your patient		

Psychological attitude: history, attitude, drug abuse etc are pertinent. Is family support available? ______________________________

Is the patient transplantable? ______________________________

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Is the candidate compliant with the treatment? ______________________________

Please include any other feature that may be pertinent and which is not included above

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PLEASE SUBMIT LATEST BLOOD TEST RESULTS: U&E AND FBC

Acknowledgement by Examinating Doctor

I certify that the particulars hereto are – to the best of my knowledge and belief – true and accurate, having conducted a personal examination and/or procured the tests and/or other diagnostic investigations referred to.

Signature of Medical Practitioner	Date	Place QR code/barcode or Stamp