Liberty Health Cover
Chronic Medicine Application Form

FOR OFFICIAL USE ONLY Member/ policy number

Important: please read the following before completing this application form
- Please write clearly using capital and block letters.
- It is compulsory to complete all the fields in this form.
- Please submit your completed form to our Liberty Health Cover in-country office.

1. PERSONAL DETAILS | PRINCIPAL MEMBER OR POLICYHOLDER

Please complete in block capitals

Last name

First names Title

Medical Insurer

Membership or policy number

ID/ Passport number

2. GENERAL PATIENT INFORMATION

Please complete in block capitals

Patient's last name

Patient's first names

Patient dependant code Gender M F

Date of birth Y Y Y Y M M D D

Home telephone (please include country and area code) +

Mobile (please include country and area code) +

Fax (please include country and area code) +

E-mail

Physical address

Postal code

Postal address (if different to physical address)

Postal code

3. DOCTOR AND PROVIDER DETAILS

Please complete in block capitals

Hospital name

Speciality

Treating doctor's last name

Treating doctor's first name

Speciality

Practice/Registration No.

Work telephone (please include country and area code) +

Fax (please include country and area code) +

Mobile (please include country and area code) +

E-mail

Physical address

Postal code

Postal address (if different to physical address)

Postal code

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

CLINICAL EXAMINATION GENERAL INFORMATION (TO BE COMPLETED FOR ALL APPLICANTS)

Please complete in block capitals

Weight (kg) Height (cm) BMI

Blood pressure (sitting, having rested for 5 minutes) MMHG Date of test Y Y Y Y M M D D

Smoking Y N Exercise Y N Tia/Stroke Y N

Please provide us with information if you have one of the following conditions:

Malaria Date of Diagnosis Y Y Y Y M M D D

Stroke Date of Diagnosis Y Y Y Y M M D D

Ischaemic heart disease Date of Diagnosis Y Y Y Y M M D D

Peripheral vascular disease Date of Diagnosis Y Y Y Y M M D D

Diabetes Date of Diagnosis Y Y Y Y M M D D

Asthma Date of Diagnosis Y Y Y Y M M D D

Hyperlipidaemia Date of Diagnosis Y Y Y Y M M D D

Drug allergies Date of Diagnosis Y Y Y Y M M D D

Other Date of Diagnosis Y Y Y Y M M D D

In order to register patients on the chronic medicine programme, documentation from a relevant specialist and/or test results verifying the diagnosis, is required for the following:

Diabetes:

Date of diagnosis Y Y Y Y M M D D

HbA1C mmol/l Date of tests done Y Y Y Y M M D D

HGT m.mg Date of tests done Y Y Y Y M M D D

Hyperlipidaemia:

Date of diagnosis Y Y Y Y M M D D

TC Date of tests done Y Y Y Y M M D D

HDL Date of tests done Y Y Y Y M M D D

TG Date of tests done Y Y Y Y M M D D

LDL Date of tests done Y Y Y Y M M D D

Diagnosis/ ICD-10 code	Active ingredients	Medicine trade name	Strength (e.g. 10mg)	Directions (e.g. 1tds)

Special investigagions/ motivations

ACKNOWLEDGEMENT BY EXAMINING DOCTOR

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

Having conducted a personal medical examination, 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.

Doctor's last name

Doctor's first name(s)

Doctor's signature Date Y Y Y Y M M D D

PATIENT'S DECLARATION

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 Liberty Health Cover Policy Conditions and benefits.

Patient's signature Date Y Y Y Y M M D D