Heritage
Insurance Company
A member of LIBERTY

THE HERITAGE INSURANCE COMPANY KENYA LIMITED
Liberty House, Processional Way
PO Box 30390-00100, Nairobi, Kenya
Contact Centre 0711 076 333
Emergency 24 Hours Service Line
0733 750004/0733 550050
0728 6077689/0728 111001/0728 111002
e chroniccare@heritage.co.ke
w www.heritageinsurance.co.ke

Managed Healthcare Application Form

GENERAL PATIENT INFORMATION

Name of main member

Name of patient

Membership no. Patient dependant code

ID number Gender M F

Date of birth D D - M M - Y Y Y Y

Tel home Tel fax

Please include country and area code Please include country and area code

Cell phone no.

Address

Postal

Postal code

Address

Residential

Postal code

Email

Preferred communication method Postal Fax Email

EMPLOYEE DETAILS

Employer name

Job description

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

Weight (kg) Height (cms) Blood pressure (sitting, having rested for 5 minutes) MMHG

Smoking Y N Exercise Y N TIA/Stroke Y N

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

Malaria Stroke Ischaemic heart disease Peripheral vascular disease Diabetes

Asthma Hyperlipidaemia Drug allergies Other _____

Member no. Dependant code

SURGICAL / MEDICAL / OBSTETRIC HISTORY

Hospital admission Date D D - M M - Y Y Y Y

Diagnosis _____

_____

Treatment _____

_____

_____

Medical admission Date D D - M M - Y Y Y Y

Diagnosis _____

_____

Treatment _____

_____

_____

Tested for Tuberculosis Date D D - M M - Y Y Y Y

Positive ☐ Negative ☐

Treatment _____

_____

_____

Tested for Malaria Date D D - M M - Y Y Y Y

Positive ☐ Negative ☐

Treatment _____

_____

_____

Allergies to medication / other _____

Currently pregnant Y ☐ N ☐ EDD _____ Gravida _____ Para _____

Current method of contraception _____

Member no. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Dependant code ☐☐☐

To be completed by the Attending Medical Practitioner (complete using block letters)

CHRONIC MEDICINE INFORMATION

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: HbA1C ☐☐☐☐☐ mmol/l HGT ☐☐☐☐☐ m.mg

Hyperlipidaemia: Lipogram ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Diagnosis/ICD-10 Code	Active ingredient	Medicine trade name	Strength e.g. 10 mg	Directions e.g. 1 TDS
1				
2				
3				
4				
5				
6				

Special investigations/motivation: _____

Member no. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Dependant code ☐☐☐

To be completed by the Attending Medical Practitioner (complete using block letters)

ONCOLOGY TREATMENT PLAN

Patient history

Date first diagnosed D D – M M – Y Y Y Y

Primary site

ICD code

Histology

Date of second diagnosis D D – M M – Y Y Y Y

Secondary

ICD code D D – M M – Y Y Y Y

Histology

Grade D D – M M – Y Y Y Y

ECOG scale

Description

PROSTATE

Volume

Gleason scale

PSA

Stage

METASTASES

Bone

Date D D – M M – Y Y Y Y

Brain

Date D D – M M – Y Y Y Y

Liver

Date D D – M M – Y Y Y Y

Lung

Date D D – M M – Y Y Y Y

Other

Receptors

Co-morbidities

TREATMENT HISTORY

Description	Drugs	Date	Outcome
		D D – M M – Y Y Y Y	
		D D – M M – Y Y Y Y	
		D D – M M – Y Y Y Y	
		D D – M M – Y Y Y Y	

Chemotherapy	Name	Active ingredients	Cycle length	Dose/frequency	Total cost

RADIOTHERAPY

Professional Practice no.

Name of radiologist

Technical/Hospital Practice no.

Name

Start date D D – M M – Y Y Y Y

End date D D – M M – Y Y Y Y

Area

Duration

Tariff codes

Member no.

Dependant code

ONCOLOGY UPDATES

Blood test description	Date	Results
	D D - M M - Y Y Y Y	
	D D - M M - Y Y Y Y	
	D D - M M - Y Y Y Y	
	D D - M M - Y Y Y Y	

Treatment change request

Chemotherapy	Name	Active ingredients	Cycle length	Dose/frequency	Total cost	Date
						D D - M M - Y Y Y Y
						D D - M M - Y Y Y Y
						D D - M M - Y Y Y Y
						D D - M M - Y Y Y Y
						D D - M M - Y Y Y Y
						D D - M M - Y Y Y Y
						D D - M M - Y Y Y Y

Member no.

Dependant code

To be completed by the Attending Medical Practitioner (complete using block letters)

ANTIRETROVIRAL AND RELATED PROPHYLACTIC TREATMENT

ANTIRETROVIRAL AND PROPHYLACTIC MEDICATION REQUESTED

Medication Name	Started	Stopped
	D D - M M - Y Y Y Y	D D - M M - Y Y Y Y
	D D - M M - Y Y Y Y	D D - M M - Y Y Y Y
	D D - M M - Y Y Y Y	D D - M M - Y Y Y Y
	D D - M M - Y Y Y Y	D D - M M - Y Y Y Y
	D D - M M - Y Y Y Y	D D - M M - Y Y Y Y

PREVIOUS ANTIRETROVIRAL MEDICATION

Medication Name	Started	Stopped
	D D - M M - Y Y Y Y	D D - M M - Y Y Y Y
	D D - M M - Y Y Y Y	D D - M M - Y Y Y Y
	D D - M M - Y Y Y Y	D D - M M - Y Y Y Y
	D D - M M - Y Y Y Y	D D - M M - Y Y Y Y
	D D - M M - Y Y Y Y	D D - M M - Y Y Y Y

Reason for stopping: _____

Member no. | | | | | | | | | | | | | | | | | Dependant code | | | |

To be completed by the Attending Medical Practitioner (complete using block letters)

ALTERNATIVE CARE MANAGEMENT

Diagnosis details

Date of diagnosis D D - M M - Y Y Y Y

Test used to diagnose

Counselling provided to patient ☐ Yes ☐ No

HIV/AIDS related symptoms:

Nervous system

Ear, nose, throat

Respiratory

Gastrointestinal

Urogenital

Skin

General

WHO Staging

Weight (kg) Height (cms)

CD4 count and percentage	Date	Results
	D D - M M - Y Y Y Y	
	D D - M M - Y Y Y Y	
	D D - M M - Y Y Y Y	
	D D - M M - Y Y Y Y	
Viral load	**Date**	**Results**
	D D - M M - Y Y Y Y	
	D D - M M - Y Y Y Y	
	D D - M M - Y Y Y Y	
	D D - M M - Y Y Y Y	

Member no. Dependant code

To be completed by the Attending Medical Practitioner (complete using block letters)

DETAILS OF THE ATTENDING MEDICAL PRACTIONER

Doctor's surname

Initials

Practice number

Address

Postal

Postal code

Email

Telephone no. Cell

Please include country and area code

Fax

ACKNOWLEDGEMENT BY EXAMINING DOCTOR

Having conducted a personal medical examination, I certify that the particulars in the above form 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 ongoing / chronic medicine/s.

Surname

First name

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

PATIENT'S DECLARATION

I hereby declare that the statements in this form are true and complete. I further declare that I have not withheld any material Information in regard to this application that ought to be disclosed to the Insurer. I agree to abide by the rules governing the Insurer and further agree that this declaration and the answers given in this application form shall be the basis of the contract between me and the insurance company.

I consent to the Insurer seeking information from any doctor, hospital or clinic I have consulted, or from any company from whom I have requested insurance and I hereby authorise the giving of such information.

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

Patient name

Membership number

Patient Surname