CHRONIC REGISTRATION FORM

PARKSMED HEALTH FUND

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All correspondence to be directed to General Manager

You Health, Our Joint Responsibility

A Member of Zimbabwe Parks & Wildlife Management Authority

New registration ☐ Update ☐

Section B: Patient details: *This section is to be completed by the patient*

Title		**Surname**		**Cellphone**	
Name/s				**Member number**	
Date of birth		**ID number**		**Suffix number**	
Patient's e-mail address					

Patient declaration statement

1. I understand that my personal and clinical information will be kept confidential
2. I give permission to my doctor to disclose the diagnosis of my condition and any facts relating to this condition to Parksmed Health Fund for purposes of registration on their chronic network and for managed care purposes ;
3. I declare that the information supplied in and with this application form is complete and accurate

Patient/member signature:_____ **Date:**_____

Section B: Service provider details: *This section must be completed by the service provider contact person*

Diagnosis	Product	Strength	Daily dose	Quantity	Number of repeats

Doctor details :					
Title		**Surname**		**Cell #**	
Name/s				**AHFoZ number**	

Service provider declaration statement

1. I have verified this application against chronic formulary and approved chronic conditions
2. I declare that the information supplied in and with this application form is complete and accurate

Service provider representative:_____ **Signature:**_____

Date:_____

Service Provider Stamp