HERITAGE HEALTH
We care about your health

Heritage Square, 100 Robert Mugabe Avenue
Office 2, Ground Floor
Box 23091, Windhoek, Namibia

+264 61 230213 / 230226 +264 61 271287
admin@heritagehealth-namibia.com
www.heritagehealth-namibia.com

A. Oncology Treatment Request

Principal Member Details Below	Membership Number
Surname	
First Names	
Personal Postal Address	
Tel Code and Number	
Fax Code and Number	
Cell Phone Number	
Email Address	
Date of Birth	D D M M Y Y Y Y
Gender	Male Female
ID/Passport Number	

B. Details of Patient if not the Principal Member

Full Names of Patient	
Tel Code and Number	
Fax Code and Number	
Cell Phone Number	
Email Address	
Date of Birth	D D M M Y Y Y Y

C. Clinical Information

Case Number	
Case Manager	
Case Manager Contact Details	
Date Received	
Diagnosis	
Date of Diagnosis	
Histology and Grade	
Disease Stage at Diagnosis	
Previous Treatment	Date: _____ Treatment: _____
Outcome of Previous Treatment	
Metastases	
Performance Status	
Measurements	Weight: Height:
Gender and Age	Gender: Age:
Proposed Treatment	Chemotherapy / Hormone Therapy / Radiation / Other/Specify
Intent of Treatment	Palliative / Curative / Radical / Neo-Adjuvant / Remission Induction / Remission Maintenance
Chemotherapy Schedule Drugs and Supporting drugs No of Cycles Planned	Chemotherapy / No of Cycles

Cost Per Cycle	
Any other Relevant Information	
Other Comments	

We thank you for your assistance as it simplifies the necessary benefit allocation for oncology treatment for your patient and the necessary associated payments.
Please submit the information to:

The Oncology Case Manager
Heritage Health Medical Aid Fund
Fax: +264 – 61 - 271287

_____ _____
SIGNATURE OF MEMBER DATE
(or authorised representative)

Undertaking to refund any payments received in lieu of the accident to the Fund within 7 days from date of receipt of the funds.

I _____, hereby undertake to refund any payments in lieu of the accident to the Fund within 7 days of receipt of the funds from the MVA Fund.

_____ _____
SIGNATURE OF MEMBER DATE

(or authorised representative)

E. Accident / Injury Processing *(office use)*

Date received: ……

Date processed: ……

Approved: ……

Declined and reason: ……

Inform patient: ……

Employee name: …… Signature: …… Date: ……