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| CHRONIC MEDICATION APPLICATION FORM |

1. To be completed by Policyholder/ Member

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| MedNet Card no.  رقم بطاقه ميدنت |  | Application Date تاريخ الطلب |  |
| Name of Insured Member اسم المؤمن عليه |  | Contact no. رقم تلفون العميل |  |
| Insurance Company  شركه التامين |  | Age: : العمر |  |
| Preferred Pharmacy اسم الصيدليه( على ان تكون من ضمن الشبكه الطبيه  (Network) |  | Signature  الاسم والتوقيع |  |

1. To be completed by Physician

Start date of disease/

Complaints (DD/MM/YY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

تاريخ بدء الشكوى المرضيه ( اليوم/الشهر/السنه

Final Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

التشخيص النهائ

ICD 10 code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

كود التشخيص

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| Trade name of Medication  السم التجاري للدواء | Dose/ Day  الجرعه/ يوم | Duration  (Number of Months)  المده ( عدد الشهور ) | Comments  ملاحظا ت |
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1. For MedNet’s Use Only

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| Date:  التاريخ | Authorization Code:  رقم الموافقه |
| Physician’s Name:  اسم الطبيب | Stamp & Signature:  الختم والتوقيع |

Note : Please verify the MedNet Card & National ID before dispensing the medications.