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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 Memberاسم المؤمن عليه |  | Contact no.رقم تلفون العميل |  |
| Insurance Companyشركه التامين |  | Age:: العمر |  |
| Preferred Pharmacyاسم الصيدليه( على ان تكون من ضمن الشبكه الطبيه(Network) |  | Signatureالاسم 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 Medicationالسم التجاري للدواء | Dose/ Dayالجرعه/ يوم | Duration(Number of Months)المده ( عدد الشهور ) | Commentsملاحظا 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.