MedNet UAE FZ L.L.C.
Paid-up capital AED 5,000,000

Chronic Medication Application Form

A. To be completed by Policyholder/Member

MedNet Card No: _____ **Contact No:** _____

Name of Insured Member: _____ **Age:** _____

Insurance Company: _____

Preferred Pharmacy:
(Network Only) _____ **Signature:** _____

B. To be completed by MedNet's Network Doctor only

Start date of Disease / Complaints (DD/MM/YY): _____

Final Diagnosis: _____

SOAP Number: _____

Trade Name of Medication	Dose/Day	Duration (No. Of Days/Months)	Comments

Date: ____/____/____

Physician's Name: _____

Stamp & Signature: _____

For MedNet's Use Only -

Authorization Code: _____

NB -

1. **Please note that all fields are mandatory and any blank will result in invalidation of this form**
2. **Please enclose the relevant medical reports and all results of the diagnostic tests.**