

**ChroniCare Network**

TEL : 04 – 793 389  
FAX : 04 – 790 700

**ChroniCare Network**

P.O. Box 10130, Harare

Dear Member

Please find attached an application form for chronic medication benefits. Kindly have the ChroniCare Network application form completed and returned to us.

Your application will be clinically assessed through a sophisticated Drug Utilisation Review process.

Details of approved items and their number of months supply will be forwarded to you, allowing for chronic medication benefits for those items.

**Kindly use the following check list when having your application completed:**

Please

- \* Ensure the correct membership number is provided
- \* Ensure that the correct patient name and surname is provided
- \* Ensure that the correct dependent code for the patient is provided
- \* Have the patient sign the relevant portion of the application form
- \* Ensure that the Pharmacy Name and Branch are provided
- \* Have your doctor complete the practitioner section in full
- \* Have your Doctor sign the relevant portion of the application form

**Thank You**

**CHRONICARE NETWORK**



**ChroniCare Network**

Tel./Fax 04-790700; 793389; 793476

**ChroniCare Network**

P.O. Box 10130, Harare

MEMBER NO

COMPANY NO

OUR REF

DATE

Members full names : \_\_\_\_\_ Membership

No: \_\_\_\_\_

Patients full names : \_\_\_\_\_ Patients Dependant

Code: \_\_\_\_\_

Patient I.D Number : \_\_\_\_\_ Members Telephone

No: \_\_\_\_\_

Pharmacy Name : \_\_\_\_\_ Branch and

Town: \_\_\_\_\_

I authorise my Medical Practitioner to furnish or disclose to CCN any facts relating to this application.

Date : \_\_\_\_\_  
\_\_\_\_\_

Patients / Members signature :

**For completion by Practitioner**

Diagnosis	Product	Strength	Daily Dose	Qty	No. of Repeats