BOTSWANA PUBLIC OFFICERS' MEDICAL AID SCHEME

Administered by Associated Fund Administrations Botswana (Pty) Ltd

Full member of the international federation of health plans

AFA THouse Plot 61918 I Showgrounds Office Park I P O Box 1212 Gaborone I Botswana I Tel: (+267) 365 0500 I Fax: (+267) 395 1165

CHANGE OF FAMILY / PRIMARY CARE FACILITY or DOCTOR

REGISTRATION FORM - CONFIDENTIAL

IMPORTANT: This form is to be used only in cases where the registered beneficiary (principal member or dependant) wishes to change his/her primary care provider for whatsoever reason, and select a new facility/doctor to provide primary care services to him/her or his/her dependant:

1. PRINCIPAL MEMBER DETAILS:

Principal Member's First name:	Surname:	Title:
Principal Member's Number:	Benefit Option:	
Medical Scheme:		

2. REGISTERED DEPENDANTS DETAILS: (To be completed for affected beneficiary(s) only)

First Name:	Surname:	Title:
First Name:	Surname:	Title:
First Name:	Surname:	Title:
First Name:	Surname:	Title:
First Name:	Surname:	Title:

3. REGISTERED DEPENDANTS DETAILS: (To be completed for affected beneficiary(s) only)

Home address?.....

Work address?.....

Telephone? (W).....Telephone?(h).....E-mail?.....

4. MY/THE FAMILY NEW PRIMARY CARE FACILITY'S / DOCTOR'S NAME AND PRACTICE NUMBER DETAILS ARE AS BELOW

Name of Doctor / Facility	Practice Number & Postal Address	Telephone:	Fax
	Practice No.		
	Postal Address:	Email Address	

4.1. Reason and Date of change of primary care provider: (*=Delete as appropriate): **Start / Effective Date: / / 20**

Moving away from current location* / Not happy with service* / Personal reasons* / .....*

Other: .....

7. ACCEPTANCE OF MEMBER / DEPENDANT(S) FOR PRIMARY CARE SERVICES

I Dr.....have accepted the above named person(s) for primary care services in my practice.

Signature:..... Official Date Stamp

I Dr / Mr / Ms ..... , being duly authorised to do so, have acccepted the abovenamed person(s) for primary care services on behalf of the facility / doctor named in (4) above.

Signature:..... Official Date Stamp

Member's / Beneficiary's Signature: ..... Date: .....

NB: This form must be completed and sent to **AFA** prior to submission of claims, to ensure appropriate payment.

PLEASE FAX COMPLETED FORM TO: (267) 395 1165