



# NATIONAL HEALTH INSURANCE APPLICATION FOR OVERSEAS MEDICAL TREATMENT FORM

Form Q

## INSTRUCTIONS

Please use block letters to complete the form. It is the physician's responsibility to verify that the information provided on this form is accurate and complete.

### PERSONAL INFORMATION (to be filled by employee)

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ GENDER: MALE  FEMALE

DATE OF BIRTH: D \_\_\_ M \_\_\_ Y \_\_\_\_\_ NHI MEMBERSHIP NUMBER: \_\_\_\_\_

PHYSICAL ADDRESS: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_ TELEPHONE: LANDLINE ( \_\_\_ ) \_\_\_\_\_ MOBILE ( \_\_\_ ) \_\_\_\_\_

NEXT OF KIN: (LAST NAME) \_\_\_\_\_ NEXT OF KIN: (FIRST NAME) \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ PHYSICAL ADDRESS: \_\_\_\_\_

TELEPHONE: LANDLINE ( \_\_\_ ) \_\_\_\_\_ MOBILE ( \_\_\_ ) \_\_\_\_\_

### REFERRAL DETAILS (to be filled by Physician)

REFERRING PHYSICIAN: (LAST NAME) \_\_\_\_\_ REFERRING PHYSICIAN: (FIRST NAME) \_\_\_\_\_

BUSINESS ADDRESS: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_ TELEPHONE: ( \_\_\_ ) \_\_\_\_\_ FAX: ( \_\_\_ ) \_\_\_\_\_

MEDICAL DIAGNOSIS: \_\_\_\_\_  
**(INCLUDING ICD 10 CODES)**

RELEVANT MEDICAL HISTORY: \_\_\_\_\_

MEDICAL SURGICAL TREATMENT BEING REFERRED: \_\_\_\_\_  
**(INCLUDING CPT CODES)**

IS THE TREATMENT AVAILABLE IN THE BVI? YES  | NO

NAME OF PHYSICIAN (LAST NAME/FIRST NAME) OR FACILITY TO WHICH YOU ARE REFERRING YOUR PATIENT: \_\_\_\_\_

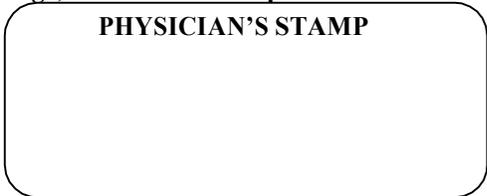
BUSINESS ADDRESS: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_ TELEPHONE: ( \_\_\_ ) \_\_\_\_\_ FAX: ( \_\_\_ ) \_\_\_\_\_

I hereby declare that the information provided above is, to the best of my knowledge, accurate and complete.

Physician's Signature: .....

Date: D \_\_\_ M \_\_\_ Y \_\_\_\_\_



Pre-certification is required for access to ALL overseas health care services that are covered under the NHI Benefit Package of Health Services, with the exception of emergency care.