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: _____ FISRT 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: _____ REFERRING PHYSICIAN: _____
(LAST NAME) (FIRST NAME)

BUSINESS ADDRESS: _____

EMAIL ADDRESS: _____ TELEPHONE: (____)_____ FAX: (____)_____

MEDICAL DIAGNOSIS: _____
(INCLUDING ICD 9 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 ____

PHYSICIAN'S STAMP

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.

OFFICIAL USE ONLY

Approval Status: _____

Officer's Name: _____ Signature:_____

Date: D____ M____ Y ____