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Electronic Claim Submissions Registration Form

USER DETAILS

PRACTICE NAME : ________________________________

PRACTITIONER NAME : ________________________________

NAMAF PRACTICE No : ____________________________

2nd PRACTITIONER : ________________________________

3rd PRACTITIONER : ________________________________

4th PRACTITIONER : ________________________________

PHYSICAL ADDRESS

Street : ________________________________

Building : ________________________________

Suite : ________________________________

Town : ________________________________

POSTAL ADDRESS

Street / Box : ________________________________

Building : ________________________________

Suite : ________________________________

Town : ________________________________

PRACTICE CONTACT DETAILS

Contact Person : ________________________________

Tel No : ________________________________

E-mail : ________________________________

Cell No : ________________________________

Fax No : ________________________________

PRACTICE MANAGEMENT SYSTEM INFORMATION (PMA)

Software Name : ____

Software / Account Manager / Sales Person : ____

Tel No : (______) __________________________

Cell : ________________________________

Fax No : (______) __________________________

Office Use

Practice Registration on MediSwitch Namibia System

Source Id : ________________________________

Password : ________________________________

Comments : ____

____

Above information is to be handled as confidential

Signed by (Full Name) : ____

Date : ________________________________ **Signature** ________________________________

Please fax the Registration Form back to the following number: 061 – 250 395