THE NATIONAL INSURANCE ACT, 1972

Commonwealth of the Bahamas

The National Prescription Drug Plan

Registration Form (DP-1)

ELIGIBILITY REQUIREMENTS

To register for the National Prescription Drug Plan a person must:

- Have a valid National Insurance number.
- Belong to one of the covered groups.
- Complete a Drug Plan Registration Form (DP-1).
- Be diagnosed with one or more of the covered chronic diseases by a licensed physician.
- Bring NIB card and valid government-issued ID when registering and collecting ACE Rx Card.

NOTES:

General Note:

Where a person is unable to register or collect a card in person due to incapacity, a written authorization is required for an appointed person to act on behalf of the incapacitated individual.

Children / Students:

- A parent or guardian must sign the registration form for children under the age of 18.
- Students age 18 – 24 years must provide a letter from their school indicating full time status. This status must be verified every six months to remain eligible for the Plan.

Pregnant Women:

In order to apply for the National Prescription Drug Plan in this group, one must:

- Be receiving ante-natal care, care connected with childbirth, post-natal care or any other medical care associated with pregnancy.
- Complete a Drug Plan Registration Form (DP-1) which must be accompanied by the Ante-natal/Post-natal Certificate (DP-6).
- Have your physician complete an Ante-natal/Post-natal Certificate (DP-6).

IMPORTANT NOTE: Coverage is extended for only six months beyond the delivery date, after which benefits will cease.

Indigents:

In order to apply for the National Prescription Drug Plan as an Indigent, one must:

- Have an income of $210 or less per week ($10,920 or less per annum).
- Complete a Drug Plan Registration Form (DP-1) which must be accompanied by the Indigent Certification Form (DP-7).
- Have the Social Services Department complete an Indigent Certification Form (DP-7) on their behalf.

Addition of New Conditions

In cases where new conditions develop after receiving the membership card, a registered NPDP member must complete an Information Change Form (DP-2) to add the new condition(s). The same procedure for registration is completed and condition(s) are added to the member's ACE Rx Card for use at any participating pharmacy.

SECTION I - TO BE COMPLETED BY APPLICANT

NI#: | | | | | | | | | |

NAME: Mr. / Mrs. / Ms. _____

Surname *First Name* *Middle*

SEX: Male ☐ Female ☐ Date of Birth: _____ P. O. Box: _____

dd/mm/yyyy

Address: _____ Island: _____

Mother's Name: _____ Father's Name: _____

Phone Contact: Home: _____ Work: _____ Cell: _____

Email Address: _____ Occupation: _____

Employer Name: _____

Name of Private Health Insurer: _____ Policy Number: _____

Does your private health insurance cover prescription drugs? Yes ☐ ☐ No

I certify that the information contained in this form is true and correct to the best of my knowledge and belief. I undertake that if this benefit is awarded I shall inform the National Prescription Drug Plan Office of any change in my condition, which may affect my entitlement to this Benefit.

_____ _____

Signature of Applicant/Guardian **Date**

COMPLETE THIS SECTION ONLY IF YOU ARE A GUARDIAN

Guardian Name: _____ Guardian NI# _____

Relationship to Client: _____ ID Type & No _____

SECTION 2 - TO BE COMPLETED BY A REGISTERED MEDICAL PRACTITIONER

I certify that _____ has the following medical condition(s):

Client's Name

*** Diagnosis must be made by Specialist.** **Home-Care Patient? Yes ☐ No ☐**

CONDITION		☑	CODE	DATE OF DIAGNOSIS
Rheumatic Diseases	• *Arthritis*			
	• *Lupus**			
Asthma				
Chronic Obstructive Pulmonary Disease (COPD)				
Benign Prostate Hypertrophy				
Breast Cancer*				
Diabetes				
Epilepsy				
Glaucoma*				
High Cholesterol				
Hypertension				
Coronary Heart Disease & Cardiomyopathy*				
Prostate Cancer*				
Psychiatric Illness	• *Dementia**			
	• *Depression*			
	• *Psychosis*			
	• *Schizophrenia*			
Sickle Cell Anemia				
Thyroid Disease				

DOCTOR'S INFORMATION

Name: _____

Office Address: _____

P. O. Box: _____

Phone Number: _____

E-mail Address: _____

Medical Registration #: _____

Signature: _____

PLACE STAMP HERE

SECTION 3 - FOR OFFICIAL USE ONLY

ID Type: Passport ☐ Drivers License ☐ Other: _____ ID Number: _____

Is claimant in receipt of NIB Benefit/Assistance? Yes ☐ No ☐ Type: _____

Application Received by: _____ Date: _____