



INDIVIDUAL BENEFITS REQUEST FORM

For use by Healthcare Professionals, NHF Beneficiaries and the General Public to recommend changes to the list of benefits on the NHF and JADEP Programme.

Not to be used by Distributors for submitting Drug Applications or by Beneficiaries for submitting requests for NHF/JADEP Card, Changing Member Details, Replacing ID card or Updating of Medical Record.

Please open and complete form in Adobe Reader, and then submit electronically to the National Health Fund.

IMPORTANT NOTE - If your request is in relation to a benefit card, please contact us at 1-888-DIAL-NHF (342-5643) or via our website.

INDICATE THE TYPE OF CHANGE.

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> New Active Ingredient | <input type="checkbox"/> New Pack Size | <input type="checkbox"/> New Illness |
| <input type="checkbox"/> New Formulation | <input type="checkbox"/> Revision of a Drug Subsidy | |
| <input type="checkbox"/> New Drug Label | <input type="checkbox"/> New Diabetic Supply | |
| <input type="checkbox"/> New Strength | <input type="checkbox"/> New Respiratory Supply | |
| <input type="checkbox"/> Other | Please Specify | <input type="text"/> |

PLEASE STATE CLEARLY BELOW DETAILS OF REQUEST BEING MADE.

PLEASE PROVIDE YOUR CONTACT INFORMATION.

- Beneficiary Pharmacist Physician Caregiver Other

Name

Phone

Address

Email

Date (mm/dd/yyyy)

Signature