

GOVERNMENT OF ZAMBIA

STATUTORY INSTRUMENT NO. 63 OF 2019

The National Health Insurance Act, 2018
(Act No. 2 of 2018)

The National Health Insurance (General) Regulations, 2019

ARRANGEMENT OF REGULATIONS

Regulation

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4. Application for health insurance by foreigner
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FIRST SCHEDULE
SECOND SCHEDULE
THIRD SCHEDULE
FOURTH SCHEDULE
FIFTH SCHEDULE

IN EXERCISE of the powers contained in section 57 of the National Health Insurance Act, 2018, the following Regulations are made:

- | | |
|---|------------------------|
| 1. These Regulations may be cited as the National Health Insurance (General) Regulations, 2019. | Title |
| 2. In these Regulations unless the context otherwise requires— | Interpretation |
| “benefit package” means the benefit package set out in the Fourth Schedule; | |
| “certificate of accreditation” means a certificate of accreditation issued under regulation 11; | |
| “citizen” has the meaning assigned to the word in the Constitution; | Cap. 1 |
| “clinic” means a health facility that provides outpatient services and includes a health facility that provides dental and vision care; | |
| “Committee” means the Health Complaints Committee of the Board continued under the Act; | Act No. 3 of 2019 |
| “employee” has the meaning assigned to the word in the Employment Code Act, 2019; | Act No. 3 of 2019 |
| “employer” has the meaning assigned to the word in the Employment Code Act, 2019; | |
| “established resident” has the meaning assigned to the word in the Immigration and Deportation Act, 2010; | Act No. 18 of 2010 |
| “hospice” means a place where a person who is terminally ill receives palliative care; | |
| “hospital” means a health facility that provides inpatient and outpatient services; | |
| “member” has the meaning assigned to the word in the Act; | |
| “membership card” means the membership card issued to a member under regulation 5; and | |
| “register” means a register established by the Authority under regulation 18; | |
| “Zambia Medicines Regulatory Authority” means the Zambia Medicines Regulatory Authority established under the Medicines and Allied Substances Act, 2013. | Act No. 3 of 2013 |
| 3. (1) Subject to subregulations (2) and (3), an eligible citizen or established resident shall register as a member of the Scheme in Form I set out in the First Schedule. | Registration as member |

- (2) An employer shall register an employee with the Authority as a member in Form I set out in the First Schedule.
- (3) A manager of a pension scheme shall register a retiree under that pension scheme as a member in Form I set out in the First Schedule.
- Application for health insurance by foreigner 4. A foreigner who enters the Republic without valid health insurance, shall, on arrival in the Republic at the port of entry, apply to a health insurance for health insurance in Form II set out in the First Schedule on payment of a fee determined by the health insurer.
- Membership card 5. (1) The Authority shall, within sixty days of receipt of registration in Form I under regulation 3, issue a membership card in Form III set out in the First Schedule.
- (2) A member shall, on receipt of the membership card under sub-regulation (1), present the membership card to an accredited health care provider in order to access a benefit package.
- Replacement of membership card 6. (1) A member whose membership card is lost, defaced or destroyed shall apply to the Authority for a replacement card in Form IV set out in the First Schedule on payment of the fee set out in the Second Schedule.
- (2) The Authority shall, within thirty days of receipt of an application under sub-regulation (1), issue a replacement membership card in Form III set out in the First Schedule.
- Change of membership status 7. A member shall inform the Authority of any change in the membership status of that member in Form V set out in the First Schedule.
- Removal of member from Scheme 8. A person ceases to be registered as a member under the Scheme if that person dies, ceases to be a citizen or established resident.
- Contribution rates 9. An employer or self-employed citizen or established resident shall pay to the Scheme a contribution consisting of the employer's contribution and the employee's contribution at the rates set out in the Third Schedule.
- Benefit package and payment mechanisms 10. (1) A member is entitled to the benefit package set out in the Fourth Schedule.
- (2) An employer or self-employed citizen or established resident who fails to pay a contribution or remit a contribution of an employee due to the Scheme as set out under sub-regulation (1) commits an offence for the purposes of section 53 of the Act.

(3) Despite sub-regulation (2), where an employer fails to pay an unremitted contribution owed by an employer due to the Scheme, the unpaid amount shall be a civil debt due to the Scheme and shall be summarily recoverable.

11. (1) A health care provider that wishes to provide an insured health care service to a member shall apply to the Authority for accreditation in Form VI set out in the First Schedule on payment of the fee set out in the Second Schedule.

Application
for
accreditation

(2) The Authority shall, where it approves an application, issue the health care provider with a certificate of accreditation in Form VII set out in the First Schedule.

(3) The Authority shall, where it rejects an application for accreditation, inform the applicant in Form VIII set out in the First Schedule.

12. The Authority shall accredit a health care provider if the health care provider

Criteria for
accreditation

(a) has the capacity to deliver the insured health care services determined by the Authority; and

(b) passes a physical inspection carried out by the Authority of the facility used by the health care provider.

13. An accredited health care provider shall display the certificate of accreditation in a conspicuous place at the place of practice.

Display of
certificate of
accreditation

14. (1) The Authority shall, where it intends to suspend or revoke an accredited health care provider's accreditation, notify the accredited health care provider of its intention to suspend or revoke the accreditation in Form IX set out in the First Schedule.

Suspension
or revocation
of
accreditation

(2) The Authority shall, notify an accredited health care provider of the suspension or revocation of accreditation in Form X set out in the First Schedule.

15. An accredited health care provider shall provide the Authority with a report of insured health care services in the format set out in the Fifth Schedule.

Reporting
requirements
for
accredited
health care
provider

16. (1) An accredited health care provider that provides a health care service to a member, shall submit a claim to the Authority in Form XI set out in the First Schedule.

Payment of
claims for
insured health
care services

- (2) The Authority shall, on receipt of a claim under sub-regulation (1), assess the claim and pay the accredited health care provider of a valid claim.
- Confidential patient record system 17. (1) An accredited health care provider shall establish and maintain an accurate, confidential patient record system in accordance with any relevant written law and health standards as may be determined from time to time.
- (2) The confidential patient record system referred to in subregulation (1) shall provide forô
- (a) unique membership identification;
 - (b) nature of benefits to be accessed by each member;
 - (c) personnel authorised to access the system;
 - (d) a legible, traceable and auditable format; and
 - (e) integrity of the patient's records.
- Accredited health care provider payment system 18. (1) An accredited health care provider shall establish and maintain a payment system that allows the Authority to receive, verify and settle claims.
- (2) The payment system referred to in subregulation (1) shall have the ability toô
- (a) submit claims manually or electronically;
 - (b) keep records of claims submitted by the accredited health care provider;
 - (c) use standardised claim forms; and
 - (d) produce periodic statements for verification by the Authority.
- Percentage of monies to be disbursed 19. The Authority shall not, in any year, expend more than ten percent of the monies held by the Fund in that year on activities or programmes referred to in section 41 (2) (b) and (c) of the Act.
- Register 20. The Authority shall establish and maintain a register of members, employers, pension schemes, self-employed citizens or established residents and accredited health care providers in Form XII set out in the First Schedule.
- Complaints 21. A member or an accredited health care provider may lodge a complaint to the Committee or Board in Form XIII set out in the First Schedule.
- Fees 22. The fees set out in the Second Schedule are the fees payable for the matters specified therein.

FIRST SCHEDULE

(Regulations 3, 4, 5, 6, 7, 11, 14, 16, 20, 21 and 22)

FORM I
(Regulation 3)**THE NATIONAL HEALTH INSURANCE MANAGEMENT AUTHORITY****The National Health Insurance Act, 2018**
(Act No. 2 of 2018)**The National Health Insurance (General) Regulations, 2019****APPLICATION FOR REGISTRATION AS MEMBER****Application No:** _____**INSTRUCTIONS**

1. Complete this form in one (1) copy.
2. Complete the applicable portions only.
3. Type or print all entries in **BLOCK/CAPITAL LETTERS**.
4. This form shall be submitted to any of the following:
 - (a) The Employer, if employed;
 - (b) The Pension Scheme Manager, if retired;
 - (c) On-line;
 - (d) Head Office of the National Health Insurance Management Authority; or
 - (e) Any other institution designated by the Authority.

REQUIREMENTS

1. Submit a certified true copy of your proof of marriage, if married.
2. Submit a certified true copy of the Birth Certificate or proof of adoption, if the beneficiary is a child.
3. Passport size photos for the applicant and all beneficiaries.
4. A certified true copy of the National Registration Card.
5. Valid permit for foreign nationals

PART A (Mandatory for ALL applicants)

A. Personal Details: Citizen/ Established Resident Foreigner
 Nationality:

Prof. <input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/>		Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	
Full Names (as they appear on NRC or Passport)			
<u>Surname Forename Other names</u>			
.....			
.....			
NRC Number: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/>		Date of Birth	
		(dd/mm/yy) :...../...../.....	
Passport Number: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
Marital status: Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/>			
If married provide the following information in relation to your spouse;			
<u>Surname Forename Other names</u>			
.....			
.....			
Date of Birth (dd/mm/yy):...../...../.....		NRC Number :	
		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/>	
Passport Number: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
Date of marriage (dd/mm/yy):/...../.....		Work Permit No:	
		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
B. Contact Details:			
Physical Address		Postal Address:	
House Number:		
.....		
Village (where applicable):		Town:	
.....		
.....		

<p>4. This section applies to students above the age of 18 years to whom the sections above do not apply.</p> <p><input type="checkbox"/> Local <input type="checkbox"/> Foreign</p>	<p><input type="checkbox"/> covered <input type="checkbox"/> not covered</p> <p>If covered attach copy of membership card.</p> <p>If not covered complete section below.</p>
<p>1.1 To be filled in by Student</p> <p>Name of Student.....</p> <p>Name and address of Training Institution</p> <p>Student Number.....</p> <p>Date of commencement with current training institution (dd/mm/yy)/...../.....</p>	<p>1.2 To be filled in by Training Institution</p> <p>We do hereby confirm that</p> <p>í í í í í í í í í í í í í í í í í í bearer of NRC</p> <p>Number <input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/> / <input type="text"/><input type="text"/> / or Permit <input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/> is a bonafide student of</p> <p>í í í í í í í í í í í í í í í í í í and became student on the í í í í í í of í í í í</p> <p>I hereby confirm that the information provided is correct to the best of our knowledge.</p> <p>Name í í í í íí í íí í í í í ..</p> <p>Position í í í í í í í í í í í í í í í í ..</p> <p>Signature í íí í í í í í í í í í í í í</p> <p>Date(dd/mm/yy) í í í /í í í /í í í ..:</p>

PART C							
1. Beneficiaries (please use separate sheet if necessary)							
	<i>Last Name</i>	<i>First Name</i>	<i>Gender (F/M)</i>	<i>Date of Birth (mm/dd/yy)</i>	<i>NRC No./ Passport No.</i>	<i>Relation to Member</i>	
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
Attach Passport Photos of proposed member and beneficiaries below							
<i>Member</i>	<i>Spouse</i>	<i>Child/ Dependant</i>	<i>Child/ Dependant</i>	<i>Child/ Dependant</i>	<i>Child/ Dependant</i>	<i>Child/ Dependant</i>	<i>Child/ Dependant</i>
CERTIFICATION BY APPLICANT							
I CERTIFY THAT THE INFORMATION AND ALL STATEMENTS PROVIDED ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF					SIGNATURE OF APPLICANT: í í í í í í í í í í í í		
					DATE: (dd/mm/yy) í í í ñ í í ñ í í ..:		

THE NATIONAL HEALTH INSURANCE AUTHORITY



FORM II
(Regulation 4)

The National Health Insurance Act
(Act No. 2 of 2018)

The National Health Insurance Regulations, 2018

TRAVEL INSURANCE REGISTRATION

INSTRUCTIONS			
1. Complete this form in one copy. 2. Accomplish the applicable portions only. 3. Type or print all entries in BLOCK/CAPITAL LETTERS . 4. This form shall be submitted to any NHIMA agent at the point of entry			
REQUIREMENTS 1. Copy of passport 2. Visa where applicable			
A. Personal Details:			
<input type="checkbox"/> Prof. <input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>			
<u>Surname Forename Other names</u> I.D Number / Passport :..... Date of Birth (dd/mm/yy) :.....			
Profession / Job	Citizenship: <input type="checkbox"/> Zambian <input type="checkbox"/> Foreign: If Foreign state your nationality í í í í í í í í í í í í í í í í í í		
Are you permanently residing in Zambia? Yes <input type="checkbox"/> No <input type="checkbox"/>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;"> If yes, state home address in Zambia </td> <td style="width: 50%; padding: 5px;"> Contact Telephone Number </td> </tr> </table>	If yes, state home address in Zambia	Contact Telephone Number
If yes, state home address in Zambia	Contact Telephone Number		
Are you a member of any other health insurance scheme (foreign)? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, state the name of the health insurance scheme		
Have you previously been a member of any Zambian Health Insurance Scheme ? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, state the name of the health insurance scheme, when and which office?		

B. Income and Tax Information	
Do you have an earned income? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes state the amount per year.	Do you receive a pension? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please state the amount.
C. Reasons for stay in Zambia	
1. <input type="checkbox"/> Tourist 2. <input type="checkbox"/> Working 3. <input type="checkbox"/> Business / conference 4. <input type="checkbox"/> Transit 5. <input type="checkbox"/> Student 6. <input type="checkbox"/> Other please specify í í í í í í í í ..	Address and contact details whilst staying in Zambia
Length of stay in Zambia <input type="checkbox"/> Days	
CERTIFICATION BY APPLICANT	
I HEREBY CERTIFY THAT THE INFORMATION AND ALL STATEMENTS HEREIN ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF	Signature of Applicant: Date:
FOR OFFICIAL USE ONLY	
DOCUMENTS SUBMITTED WHERE APPLICABLE 1. <input type="checkbox"/> Copy of I.D/Passport 2. <input type="checkbox"/> Passport size photos 3. <input type="checkbox"/> Other (please specify) í í í í í í í í í í í .	RECEIVED BY: DATE: (dd/mm/yy) í í í /í í í /í:
	APPROVED BY: DATE: (dd/mm/yy) í í í /í í í /í í :

THE NATIONAL HEALTH INSURANCE AUTHORITY





FORM III
(Regulation 5(1) and 6 (2))

The National Health Insurance Act, 2018
(Act No. 2 of 2018)

The National Health Insurance (General) Regulations, 2019

MEMBERSHIP CARD

Front		Back
 REPUBLIC OF ZAMBIA	 NHIMA	BIOMETRIC CODE
THE NATIONAL HEALTH INSURANCE MEMBERSHIP CARD		<p>IMPORTANT: This card is valid for five (5) years and subject to replacement after five years.</p> <p>If found, this card must be returned to the National Health Insurance Management Authority offices or nearest Police station.</p> <p>Tel No. í Email Address: í í í í í í Website í í í í í í í í í .. Serial Number: í í í</p>
Picture of Card Holder	NAME: DATE OF BIRTH: SEX: DATE OF ISSUE: DATE OF EXPIRY: MEMBERSHIP NO.:	

THE NATIONAL HEALTH INSURANCE MANAGEMENT AUTHORITY



FORM IV
(Regulation 6 (1))

The National Health Insurance Act, 2018
(Act No. 2 of 2018)

The National Health Insurance (General) Regulations, 2019

APPLICATION FOR REPLACEMENT OF MEMBERSHIP CARD

INSTRUCTIONS			
1. Complete this form in one (1) copy. 2. Complete the applicable portions to be changed only. 3. Type or print all entries in BLOCK/CAPITAL LETTERS. 4. This form shall be submitted to any of the following: (a) The Employer, if employed; (b) The Pension Scheme Manager, if retired; (c) On-line; (d) Head Office of the National Health Insurance Management Authority; or Any other institution designated by the Authority			
Check appropriate box only:			
Reason for Card Replacement			
<input type="checkbox"/> LOST	<input type="checkbox"/> DAMAGED / DEFACED	<input type="checkbox"/> STOLEN	<input type="checkbox"/> OTHER
Membership Number:			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Signature: _____ Date: _____			
FOR OFFICIAL USE ONLY			
Received by: _____ Date: _____			

1. Correction of Name			
From:		To:	
2. Correction of Date of Birth			
From:		To:	
3. Change in Marital Status			
<input type="checkbox"/> Due to marriage <input type="checkbox"/> Other Reason (Specify) _____			
From:		To:	
4. Change in frequency of payment			
From:		To: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually	
5. Updating of Beneficiary (please use separate sheet if necessary)			
Last Name	First Name	Date of Birth (mm/dd/yy)	Relation Addition/ deletion
a.		<input type="text"/>
b.		<input type="text"/>
c.		<input type="text"/>
6. Change of address/contact details			
Previous Address		Present Address	
House Number:		House Number:	
Street Name:		Street Name:	
Town:		Town:	
Province:		Province:	
Contact Number:		Contact Number:	
Email address:		Email address:	
7. Change in work status			
1. <input type="checkbox"/> Change of Employer 2. <input type="checkbox"/> Promotion 3. <input type="checkbox"/> Termination/Redundancy 4. <input type="checkbox"/> Demotion 5. <input type="checkbox"/> Self Employed 6. <input type="checkbox"/> Other, please specify: Date of Change: (dd/mm/yy)/...../.....			
Details of old employer, if applicable: Name: í í í í í í í í í í í í í í í í . Address: í í í í í í í í í í í í í í í í . Contact Number: í í í í í í í í í í í í í í .		Details of new employer, if applicable: Name: í í í í í í í í . Address: í í í í í í . Contact Number: í í	

Certification	
I CERTIFY THAT THE INFORMATION AND ALL STATEMENTS PROVIDED ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.	SIGNATURE OF MEMBER DATE: (dd/mm/yy)/...../.....
FOR OFFICIAL USE ONLY	
DOCUMENTS SUBMITTED 1. <input type="checkbox"/> Copy of Birth Certificate / Records / Affidavit / Proof of birth 2. <input type="checkbox"/> Copy of Marriage Certificate / Proof of marriage 3. <input type="checkbox"/> Copy of Death Certificate 4. <input type="checkbox"/> Copy of Court Order 5. <input type="checkbox"/> Other (Please specify)	RECEIVED BY: DATE: (dd/mm/yy)/...../.....
	APPROVED BY: DATE: (dd/mm/yy)/...../.....

THE NATIONAL HEALTH INSURANCE MANAGEMENT AUTHORITY

FORM VI
(Regulation 11 (1))The National Health Insurance Act, 2018
(Act No. 2 of 2018)

The National Health Insurance (General) Regulations, 2019

APPLICATION FOR ACCREDITATION AS HEALTH CARE PROVIDER

INSTRUCTIONS		
1. Complete this form in one (1) copy.		
2. Complete the applicable portions only.		
3. Type or print all entries in BLOCK/CAPITAL LETTERS.		
4. This form shall be submitted online or to the Head Office of the National Health Insurance Management Authority.		
REQUIREMENTS		
Health Professions Council of Zambia registration No.		
A. NAME OF HEALTH CARE PROVIDER		
B. LOCATION (Plot Number, street name, town and province)		
C. POSTAL ADDRESS		
Tel No. 1	Tel No. 2	Tel No. 3
Fax:		Email:
Town:	District:	Province:
D. NAME OF CHIEF EXECUTIVE / ADMINISTRATOR / PROPRIETOR:		
<input type="checkbox"/> Prof. <input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.		
Type of Application:		
1. Initial <input type="checkbox"/> 2. Re-accreditation <input type="checkbox"/>		
If application is for re-accreditation, when was your accreditation revoked:		
1. INITIAL ACCREDITATION OF HEALTH CARE PROVIDER		
Level Applied For:		
1.1 <input type="checkbox"/> Hospital	1.1 <input type="checkbox"/> Doctors	
1.2 <input type="checkbox"/> Hospice	1.2 <input type="checkbox"/> Nurses	
1.3 <input type="checkbox"/> Clinic	1.3 <input type="checkbox"/> Dentists	
1.4 <input type="checkbox"/> Laboratory	1.4 <input type="checkbox"/> Pharmacists	
1.5 <input type="checkbox"/> Diagnostic Centre		
1.6 <input type="checkbox"/> Pharmacy		
1.7 <input type="checkbox"/> Ambulance Service		

2. CERTIFICATION BY APPLICANT	
I CERTIFY THAT THE INFORMATION AND ALL STATEMENTS PROVIDED ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.	SIGNATURE OF APPLICANT: í í í í í í í í í í í í í í í í í . DATE: (dd/mm/yy) í í í í í . / í í í í í í í í í í í í í í í í í
FOR OFFICIAL USE	
DOCUMENT SUBMITTED WHERE APPLICABLE:	APPROVED <input type="checkbox"/> NOT APPROVED <input type="checkbox"/>
1. <input type="checkbox"/> copy of certificate of incorporation of registration of business name	SIGNATURE: í . DATE: (dd/mm/yy) í í í í í . / í í í í í í í í í í í í í í í í í
2. <input type="checkbox"/> Proof of accreditation with other relevant authority (e.g HPCZ) other (please specify) í í í í í í í .	REASONS FOR NOT APPROVING: a. b. c. d.
3. <input type="checkbox"/> valid licence to provide services (e.g HPCZ) from other relevant authority	
4. <input type="checkbox"/> Other (please specify)	
Note: * HPCZ- Health Professions Council of Zambia	

THE NATIONAL HEALTH INSURANCE MANAGEMENT AUTHORITY



FORM VII
(Regulation 11 (2))

The National Health Insurance Act, 2018
(Act No. 2 of 2018)

The National Health Insurance (General) Regulations, 2019

CERTIFICATE OF ACCREDITATION

This is to certify that

.....

is **ACCREDITED** by the

National Health Insurance Management Authority of Zambia

To provide insured health care services in

í

Dated this í í í í í íday ofí í í í í í í í í í í í , 20í í í í í í í í

Accreditation No.: í í í í í í í í í í í í í í í í ..

í í í í í í í í í í í í í í í í ..

Director-General

OFFICIAL STAMP

Conditions of accreditation see overleaf.
[Reverse side]

[Reverse side]

Attached conditions

- (a) This accreditation certificate is not transferrable.
- (b) The accredited health care provider shall adhere to
 - (i) the provisions in the Act and these Regulations.
 - (ii) the reporting requirements of insured health care services.
 - (iii) national quality assurance systems set by the Authority or other relevant regulatory institutions.
- (c) In the event that the accreditation certificate is revoked, you are expected to surrender this certificate to the Authority.

THE NATIONAL HEALTH INSURANCE MANAGEMENT AUTHORITY



FORM VIII
(Regulation 11 (3))

The National Health Insurance Act, 2018
(Act No. 2 of 2018)

The National Health Insurance (General) Regulations, 2019

NOTICE OF REJECTION OF APPLICATION FOR ACCREDITATION

(1) Here insert the full names and address To (1)

(2) Here insert allocated No IN THE MATTER OF (2) you are notified that your application for accreditation has been rejected on the following grounds:

- (a) í
(b) í
(c) í

Dated this í day of í, 20í

í í í í í í í í í í í ..

OFFICIAL STAMP

Director-General

NOTE: Section 28 of the Act and Regulation 11 of the National Health Insurance (General) Regulations, 2019 govern this matter. Should you wish to challenge this suspension?

please contact as the Authority on the following address:

Address:

THE NATIONAL HEALTH INSURANCE MANAGEMENT AUTHORITY



FORM IX
(Regulation 14 (1))

The National Health Insurance Act, 2018
(Act No. 2 of 2018)

The National Health Insurance (General) Regulations, 2019

NOTICE OF INTENTION TO *SUSPEND / REVOKE ACCREDITATION

1. Here insert the full names and address of holder

TO (1)

2. Here insert the NHIMA Accreditation No

IN THE MATTER OF (2) you are notified that the Authority intends to *suspend/revoke your accreditation to provide insured health care services under the National Health Insurance Scheme on the following grounds:

(a)

(b) í ..

(c) í ..

3. Here insert the number of days

Accordingly, you are requested to show cause why your accreditation should not be *suspended/revoked and to take action to remedy the breaches set out in paragraphs í í í í í í í í í . (above) within (3) í í í í . days of receiving this notice. Failure to remedy the said breaches shall result in the *suspension/revocation of your accreditation.

Dated this day of 20.....

.....
Director-General



NOTE:

- (a) *Delete as appropriate
- (a) Section 30 of the Act and Regulation 14 of the National Health Insurance (General) Regulations, 2019 govern this matter. Should you wish to challenge this intention, please contact our Offices as follows:

Address:
.....
.....

THE NATIONAL HEALTH INSURANCE MANAGEMENT AUTHORITY



FORM X
(Regulation 14 (2))

The National Health Insurance Act, 2018
(Act No. 2 of 2018)

The National Health Insurance (General) Regulations, 2019

NOTICE OF SUSPENSION/REVOCAION OF ACCREDITATION

(1) Here insert the full names and address of holder

TO (1)
.....

(2) Here insert the NHIMA Accreditation No.

IN THE MATTER OF (2) you are notified that your accreditation to provide insured health care services has been *suspended/revoked on the following grounds:

- (a).....
- (b)í í
- (c)í í

Dated this day of 20.....

.....

Director-General

OFFICIAL
STAMP

THE NATIONAL HEALTH INSURANCE MANAGEMENT AUTHORITY



FORM XI
(Regulation 16 (1))

The National Health Insurance Act, 2018

(Act No. 2 of 2018)

The National Health Insurance (General) Regulations, 2019

HEALTH CARE PROVIDER PAYMENT CLAIM

(Form to be completed by the service provider in the presence of the member)

ACCREDITATION NUMBER: <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/>		
NAME OF HEALTH CARE PROVIDER: í		
SECTION 1: MEMBER DETAILS		
Membership Number: <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/>		
PERSONAL DETAILS		
Prof. <input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>		
Full Names (as they appear on NRC or other identification document)		
<i>Surname</i>	<i>Forename</i>	<i>Other names</i>
.....
NRC Number <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> / <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> / <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/>		
Date of Birth: (dd/mm/yy)/...../.....		
Permit Number: (where applicable) <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/>		
Address:		
í		
í í		
í í		
Mobile Number: í í í í í í í í í í í í í .		

SECTION 2: TREATMENT DETAILS (To be completed by attending practitioner)		
Diagnosis:		
Is this a post discharge following previous hospitalisation? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes, please indicate the date when the member was discharged: (dd/mm/yy) <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
Is the condition work related or an occupational illness? Yes No		
If yes, please explain:		
When was the condition first diagnosed? (dd/mm/yy) <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
Cause of illness (es)? í . í . í . í .		
Is the condition likely to recur? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Is the condition congenital? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Clinical Summary:		
WORK/OCCUPATIONAL ILLNESS OR INJURY		
Date of Accident: (dd/mm/yy) <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
Cause of accident:	Time of accident:	Place of occurrence
Patients date of admission: (dd/mm/yy) <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
Patients date of discharge: (dd/mm/yy) <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
Please attach a copy of Police Report		

FOR OFFICIAL USE						
<i>Line</i>	<i>Tariff No.</i>	<i>Description of service provided</i>	<i>Date</i>	<i>Fee charged</i>	<i>Award</i>	<i>Reason</i>
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
Total Fee Charged: í í í						
Total Awarded*: í í í í í í í í í í í í						
*For Official use						
I certify that- I, or members of my staff, have rendered the above services to or on behalf of the patient; I confirm that to the best of my knowledge and belief, the patient treated is the patient named on this form; and I agree that any claim for services not provided would be regarded as fraudulent and render the person concerned liable to prosecution.						
If there are any matters you wish to bring to the attention of the Authority Administrator, tick this box and make your comments on a separate attachment. Name of Attending Physician: í í í í í í í í í í í í í í í í Practising Licence No. of Attending Physician: í í í í í í í í í í í í í í í í ...						
<hr style="width: 50%; margin-left: 0;"/> Signature and Official Stamp of the Provider of Services						
<hr style="width: 50%; margin-left: 0;"/> Date: (dd/mm/yy)						
í í í /í í í í í í í /í í í í í						

THE NATIONAL HEALTH INSURANCE MANAGEMENT AUTHORITY



FORM XIII
(Regulation 21)

The National Health Insurance Act, 2018
(Act No. 2 of 2018)

The National Health Insurance (General) Regulations, 2019

NOTICE OF COMPLAINT

IN THE MATTER OF í

(Application reference and matter of appeal) I give notice of complaint against the decision of the Authority/Health Complaints Committee due to the following reasons:

- (a) í
- (b) í
- (c) í ..
- (d) í ..
- (e) í ..

Dated this í í í í í í í í . day of í í í í í í í í í . 20í í í í í í í

í ..

Signature of Compliant

Note: Attach brief if necessary.

SECOND SCHEDULE
(Regulations 4,6, 11, and 22)

PRESCRIBED FEES

1. Membership	<i>Fee Units</i>
	<i>Initial Replacement</i>
Membership Card	Not Applicable 100.00
2. Accreditation of health care providers	
<i>Category</i>	<i>Fee Units</i>
Hospital	40,000
Hospice	40,000
Clinic	20,000
Laboratory, Diagnostic centre and Pharmacy	20,000
Ambulance service	20,000

THIRD SCHEDULE
(Regulations 9 and 10 (2))

CONTRIBUTION RATES

<i>No.</i>	<i>Category</i>	<i>Payment Mechanism</i>	<i>Rate</i>	<i>Frequency</i>	<i>Deadline</i>
1.	Employee	Payroll based	1% of basic salary	Monthly	10th of the following Month
2.	Employer	Payroll based	1% of basic salary	Monthly	10th of the following Month
3.	Self-employed	Direct payment	1% of declared income	Monthly	10th of the following Month

FOURTH SCHEDULE

*(Regulation 10 (1))***BENEFIT PACKAGE**

The National Health Insurance Benefit Package includes the following:

1. Medical Care

- 1.1. Consultations, examinations
- 1.2. Diagnostic services (Radiology and laboratory)
- 1.3. Nursing Care
- 1.4. Hospitalisation
- 1.5. Intensive Care Unit

2. Surgery:

- 2.1. General Surgery
- 2.2. Anaesthetics
- 2.3. Orthopaedics
- 2.4. Paediatric Surgery
- 2.5. Ear, Nose and Throat

3. Maternity and Neonatal Care:

- 3.1. Antenatal Care
- 3.2. Delivery (Normal or Assisted)
- 3.3. Caesarean Section
- 3.4. Postnatal Care

4. Eye Care Services:

- 4.1. Selected services

5. Oral Health Services:

- Selected services

6. Pharmaceutical Drugs and Supplies:

- 6.1. Prescription generic drugs on the essential drugs list prescribed by an accredited health care provider an approved or use under the Scheme.
- 6.2. Medical supplies
- 6.3. Blood products

7. Physiotherapy:

- 7.1. Selected services

The National Health Insurance benefit package shall not include-

1. Treatment Abroad
2. Cosmetic surgery and aesthetic treatments (except reconstructive surgery which it is medically required)
3. Weight loss procedures and treatment
4. Long-term inpatient nursing care (over 90 days)
5. Medical treatment of motor vehicle accident injuries covered by other insurance/funds arrangements, such as motor vehicle insurance and a Motor Vehicle Accident Fund.
6. Treatment of occupational accidents and illness covered by Worker's Compensation Fund.
7. Treatment of injuries resulting from declared national disasters in collaboration with the National Disaster Management and Mitigation Unit.
8. Fertility treatment according to set criteria.

FIFTH SCHEDULE
(Regulation 15)

<i>S/N</i>	<i>Category</i>	<i>Frequency</i>	<i>Deadline</i>
1.	Statistical data on members enrolled with the health care provider	Quarterly	10th day after the end of the quarter
2.	The insured health care services provided during the reporting period and the conditions under which the services were provided	Quarterly	10th day after the end of the quarter
3.	The number and skills of staff of the health care provider	Annually (January to December)	31st January of the following the reporting period
4.	The type and state of equipment and infrastructure of the health care provider	Annually (January to December)	31st January of the year following the reporting period
5.	The inventory of medicines including stock levels available	Quarterly	10th day after the end of the quarter
6.	The relationship with other accredited health care providers and the details thereof	Annually (January to December)	31st January of the year following the reporting period
7.	Administrative, financial or medical information relevant to the provision of quality insured health care services	Annually (January to December)	31st January of the year following the reporting period

LUSAKA
19th September, 2019
[MH.101/22/10]

DR. C. CHILUFYA,
Minister of Health