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

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

Title

1. These Regulations may be cited as the National Health Insurance (General) Regulations, 2019.

Interpretation

2. In these Regulations unless the context otherwise requires—

"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

Registration as member

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.

(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.

Application for accreditation

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.

(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.

Criteria for accreditation

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

(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.

Display of certificate of accreditation

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

Suspension or revocation 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.

(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.

Reporting requirements for accredited health care provider

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.

Payment of claims for insured health care services

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.

(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 refereed to in subregulation (1) shall provide for—

(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 to—

(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 HEALH 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 poof 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. ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sex: Male ☐ Female ☐

Full Names (as they appear on NRC or Passport)

Surname Forename Other names

.....

.....

NRC Number: ☐☐☐☐☐☐ / ☐☐ / ☐ Date of Birth (dd/mm/yy) :...../...../.....

Passport Number: ☐☐☐☐☐☐☐☐☐☐☐☐

Marital status: Married ☐ Single ☐ Widowed ☐

If married provide the following information in relation to your spouse;

Surname Forename Other names

.....

.....

Date of Birth *(dd/mm/yy)*:...../...../..... NRC Number : ☐☐☐☐☐☐ /☐☐/ ☐

Passport Number: ☐☐☐☐☐☐☐☐☐☐☐☐

Date of marriage *(dd/mm/yy)*: ...../...../..... Work Permit No: ☐☐☐☐☐☐☐☐☐☐☐☐

B. Contact Details:

Physical Address

House Number:

.....

.....

Village (where applicable):

.....

.....

Postal Address:

.....

.....

Town:

.....

.....

Chief (where applicable): .... Street Name: .... Town..... ..... District:…….. ..... Province:…….. ..... Contact Number:……... ..... Email address:……..	District: .... Province: ....

PART B

Check appropriate box only and complete the parts applicable.

Salaried Employee	Self - employed citizen/ established resident	Retiree	Student	Other (Please specify)
☐	☐	☐	☐	☐

1.Salaried Employee

1.1 To be filled in by the Employee	**1.2 To be filled in by the Employer**
Name of Employer: ..... Address of Employer	We do confirm that, …… bearer of NRC Number ☐☐☐☐☐☐ / ☐☐ / ☐ or Work Permit Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ is a bonafide employee of ……and became an employee on the …… of ……, 20……

Employment Number:	I confirm that the information provided is correct to the best of our knowledge and belief: Name: .....
Date of commencement with current Employer: *(dd/mm/yy)* ……/……/……	Position: ..... Signature: ..... Date*(dd/mm/yy)* ……/……/……

2. Self-employed

Tick appropriate box (es) that apply; 2.1 ☐ WholesaleTrading 2.2 ☐ Retail Trading 2.3 ☐ Transport 2.4 ☐ Agriculture 2.5 ☐ Mining 2.6 ☐ Fishing 2.7 ☐ Construction 2.8 ☐ Trade Skills 2.9 ☐ Others (please specify……)	Average income per month:……

3. Retiree: Early ☐ Normal ☐ Late ☐

3.1 To be filled in by the Pension Scheme Manager Name of Pensioner Scheme: .... Address of Pension Scheme: .... Pension Number: ..... Date of Retirement: *(dd/mm/yy)* ...../...../.....	**3.2 To be filled in by the Pension Scheme Manager** We do confirm that …… bearer of NRC Number ☐☐☐☐☐☐ /☐☐/☐ is a bonafide member of ..... and became a member on the …… of……....., 20…….. We confirm that the information provided is correct to the best of our knowledge and belief. Name:…… Position:…… Signature: .....…… Date: *(dd/mm/yy)* ……/……/……

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

PART C

1. Beneficiaries (please use separate sheet if necessary)

	Last Name	*First Name*	*Gender (F/M*	*Date of Birth (mm/dd/ yy)*	*NRC No./ Passport No.*	*Relation to Member*
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

Attach Passport Photos of proposed member and beneficiaries below

Member	*Spouse*	*Child/ Dependant*	*Child/ Dependant*	*Child/ Dependant*	*Child/ Dependant*	*Child/ Dependant*	*Child/ Dependant*

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:

……

DATE: *(dd/mm/yy)*

……/……/……..:

FOR OFFICIAL USE ONLY	
DOCUMENTS SUBMITTED WHERE APPLICABLE 1. ☐ Copy of Birth Certificates / Record / Affidavit/Proof of Adoption 2. ☐ Copy of Marriage Certificate/Proof of Marriage 3. ☐ Copy of PACRA Registration 4. ☐ Copy of I.D 5. ☐ Passport size photos 6. ☐ Valid permit for foreign nationals 7. ☐ Other (please specify) ……	RECEIVED BY: DATE: *(dd/mm/yy)* ……/……/……. APPROVED BY: DATE: *(dd/mm/yy)* ……/……/……..

Membership Number Allocated:

THE NATIONAL HEALH 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:

☐ Prof. ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. Sex: Male ☐ Female ☐

Surname Forename Other names

.....
.....
.....

I.D Number / Passport :.....

Date of Birth *(dd/mm/yy)* :.....

Profession / Job	Citizenship: Zambian ☐ Foreign: ☐ If Foreign state your nationality ……
Are you permanently residing in Zambia? Yes ☐ No ☐	If yes, state home address in Zambia Contact Telephone Number
Are you a member of any other health insurance scheme (foreign)? Yes ☐ No ☐	If yes, state the name of the health insurance scheme
Have you previously been a member of any Zambian Health Insurance Scheme? Yes ☐ No ☐	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 ☐ No ☐ If yes state the amount per year.	Do you receive a pension? Yes ☐ No ☐ If yes, please state the amount.
C. Reasons for stay in Zambia	
1. ☐ Tourist 2. ☐ Working 3. ☐ Business / conference 4. ☐ Transit 5. ☐ Student 6. ☐ Other please specify……..	Address and contact details whilst staying in Zambia
Length of stay in Zambia ☐ 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. ☐ Copy of I.D/Passport 2. ☐ Passport size photos 3. ☐ Other (please specify) ……..	RECEIVED BY: DATE: *(dd/mm/yy)* ……/……/…..: APPROVED BY: DATE: *(dd/mm/yy)* ……/……/…….:

THE NATIONAL HEALH 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

REPUBLIC OF ZAMBIA

THE NATIONAL HEALTH INSURANCE MEMBERSHIP CARD

Picture of Card Holder

NAME: .....

.....

DATE OF BIRTH: .....

SEX: .....

DATE OF ISSUE: .....

DATE OF EXPIRY: .....

MEMBERSHIP NO.: .....

Back

BIOMETRIC CODE

IMPORTANT: This card is valid for five (5) years and subject to replacement after five years.

If found, this card must be returned to the National Health Insurance Management Authority offices or nearest Police station.

Tel No. .....
Email Address: .....
Website .....
Serial Number: .....
.....

THE NATIONAL HEALH 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

☐	☐	☐	☐
LOST	DAMAGED/DEFACED	STOLEN	OTHER

Membership Number: ☐☐☐☐☐☐☐☐

Signature: _____ Date: _____

FOR OFFICIAL USE ONLY

Received by: _____ Date: _____

_____

THE NATIONAL HEALH INSURANCE MANAGEMENT AUTHORITY

FORM V
(*Regulation* 7)

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

The National Health Insurance (General) Regulations, 2019

CHANGE OF MEMBERSHIP STATUS

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
   (e) Any other institution designated by the Authority.

REQUIREMENTS

1. For change of name and/or marital status because of marriage, submit a certified true copy of the proof of marriage.
2. For correction/change of name and/or marital status for reason other than marriage, submit a certified true copy of the Birth Certificate, or any other proof of birth document, Court Order or Death Certificate of the deceased spouse, whichever is applicable.
3. For correction of date of birth, submit a certified true copy of the Birth Certificate or any other proof birth document.
4. For updating of beneficiary information, submit a certified true copy of the Birth Certificate or any other proof of birth document of the additional beneficiary to establish relationship with the member.

Tick appropriate box only:

Correction of Name	*Correction of Date of Birth*	*Change in Marital Status*	*Change in frequency of payment/ any other financial status*	*Updating of Beneficiary*	*Change of address/ contact details*	*Change in work status*
☐	☐	☐	☐	☐	☐	☐

Other reason for change, please specify:
.....

Membership Number: ☐☐☐☐☐☐☐☐

1. Correction of Name

From:	To:

2. Correction of Date of Birth

From:	To:

3. Change in Marital Status

☐ Due to marriage ☐ Other Reason (Specify)_____ **From:**	**To:**

4. Change in frequency of payment

From:	To: ☐ **Monthly** ☐ **Quarterly** ☐ **Semi-Annually** ☐ **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.		☐☐☐☐☐☐		.....
b.		☐☐☐☐☐☐		.....
c.		☐☐☐☐☐☐		.....

6. Change of address/contact details

Previous Address	**Present Address**
House Number: ..... Street Name: ..... Town: ..... Province: ..... Contact Number: ..... Email address:	House Number: ..... Street Name: ..... Town: ..... Province: ..... Contact Number: ..... Email address: .....

7. Change in work status

1. ☐ Change of Employer 2. ☐ Promotion 3. ☐ Termination/Redundancy 4. ☐ Demotion 5. ☐ Self Employed 6. ☐ Other, please specify: ..... Date of Change: (*dd/mm/yy*) ...../...../.....	
Details of old employer, if applicable: Name:…….. Address:…… Contact Number:……..	**Details of new employer, if applicable:** Name:…… Address:……..… Contact Number…….....

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. ☐ Copy of Birth Certificate / Records / Affidavit / Proof of birth 2. ☐ Copy of Marriage Certificate / Proof of marriage 3. ☐ Copy of Death Certificate 4. ☐ Copy of Court Order 5. ☐ Other (Please specify)	RECEIVED BY: DATE: (dd/mm/yy) ...../...../..... APPROVED BY: DATE: (dd/mm/yy) ...../...../.....

THE NATIONAL HEALH 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:

☐ Prof. ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms.

Type of Application:

1. Initial ☐ 2. Re-accreditation ☐

If application is for re-accreditation, when was your accreditation revoked:

.....

1. INITIAL ACCREDITATION OF HEALTH CARE PROVIDER

Level Applied For:	
1.1 ☐ Hospital	1.1 ☐ Doctors
1.2 ☐ Hospice	1.2 ☐ Nurses
1.3 ☐ Clinic	1.3 ☐ Dentists
1.4 ☐ Laboratory	1.4 ☐ Pharmacists
1.5 ☐ Diagnostic Centre	
1.6 ☐ Pharmacy	
1.7 ☐ 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:
……..

DATE: (*dd/mm/yy*) ……../
……../……

FOR OFFICIAL USE

DOCUMENT SUBMITTED WHERE APPLICABLE:

1. ☐ copy of certificate of incorporation of registration of business name
2. ☐ Proof of accreditation with other relevant authority (e.g HPCZ) other (please specify) ……..
3. ☐ valid licence to provide services (e.g HPCZ) from other elevant authoity
4. ☐ Other (please specify)

Note: * HPCZ- Health Professions Council of Zambia

APPROVED ☐ NOT APPROVED ☐

SIGNATURE:
……

DATE: (*dd/mm/yy*) ……../
……../……

REASONS FOR NOT APPROVING:

a. .....
b. .....
c. .....
d. .....

THE NATIONAL HEALH 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

……..

Dated this ……..day of……, 20……

Accreditation No.: ……..

……

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 HEALH 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) .....

(b) .....

(c) .....

Dated this ..... day of ....., 20.....

..... 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 HEALH 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)……..

(c)……..

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 …… (above) within (3) …… 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

OFFICIAL STAMP

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 HEALH 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/REVOCATION 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).....

(c).....

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

.....

OFFICIAL STAMP

Director-General

THE NATIONAL HEALH 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: ☐☐☐☐☐☐☐☐☐☐☐☐

NAME OF HEALTH CARE PROVIDER: ……

SECTION 1: MEMBER DETAILS

Membership Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

PERSONAL DETAILS

Prof. ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sex: Male ☐ Female ☐

Full Names (as they appear on NRC or other identification document)

Surname	*Forename*	*Other names*
.....	.....	.....

NRC Number ☐☐☐☐☐☐/☐☐/☐ Date of Birth: *(dd/mm/yy)*
...../...../.....

Permit Number: (where applicable ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Address:
……
……
……
Mobile Number: ……

SECTION 2: TREATMENT DETAILS (To be completed by attending practitioner)

Diagnosis:

Is this a post discharge following previous hospitalisation? Yes ☐ No ☐

If yes, please indicate the date when the member was discharged: (*dd/mm/yy*) ☐☐/☐☐/☐☐☐☐

Is the condition work related or an occupational illness? Yes No

If yes, please explain: .....

.....

When was the condition first diagnosed? (*dd/mm/yy*) ☐☐/☐☐/☐☐☐☐

Cause of illness (es)?

……..

……..

……..

……..

Is the condition likely to recur? Yes ☐ No ☐

Is the condition congenital? Yes ☐ No ☐

Clinical Summary:

WORK /OCCUPATIONAL ILLNESS OR INJURY

Date of Accident: (*dd/mm/yy*) ☐☐/☐☐/☐☐☐☐

Cause of accident: Time of accident: Place of occurrence

Patients date of admission: (*dd/mm/yy*) ☐☐/☐☐/☐☐☐☐

Patients date of discharge: (*dd/mm/yy*) ☐☐/☐☐/☐☐☐☐

Please attach a copy of Police Report

FOR OFFICIAL USE

Line	*Tariff No.*	*Description of service provided*	*Date*	*Fee charged*	*Award*	*Reason*
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

Total Fee Charged: ……

Total Awarded*: ……

*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: ……

Practising Licence No. of Attending Physician: ……

Signature and Official Stamp of the Provider of Services

Date: (*dd/mm/yy)*

……/……/……

THE NATIONAL HEALTH INSURANCE MANAGEMENT AUTHORITY

Form XII
(Regulation 20)

The National Health Insurance Act, 2018
(Act No. 2 of 2018)
The National Health Insurance (General) Regulations, 2019

REGISTER

1. Contributing Member

S/N	*Full name*	*NRC*	*Membership ID*	*Date of birth*	*Sex*	*Marital status*	*Physical Address*	*Contact details*		*Number of dependants*[1]	*Nationality*	*Date of first enrolment*	*Occupational status*
								Phone No.	*Email*				
1.													
2.													
3.													
4.													
5.													

2. Accredited Health Care Providers

S/N	Provider name	Service type	Physical Address	Type of facility (Government, private or faith based and others)	NHIMA Accreditation number	Date of accreditation	Contact details	
							Phone	Email
1.								
2.								

3. Employers

S/N	Business or company name	NHIMA Identification Number	Employer type	Physical Address	Date of registration	Number of employees	Contact details	
							Phone	Email
1.								
2.								

4. Pension scheme

S/N	Name of pension scheme	NHIMA Identification Number	Physical Address	Date of registration	Number of pensioners	Contact person	Contact details	
							Phone	Email
1.								
2.								

5 Self employed ciitizens or established residents

S/N	Full name	Sector	NRC	NHIMA Identification Number	Date of birth	Sex	Marital status	Physical Address	Contact details		Number of dependants	Nationality	Date of first enrolment	Current membership status
									Phone	Email				
1														
2														

THE NATIONAL HEALH 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 ……

(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)……

(b)……

(c)……

(d)……

(e)……

Dated this …… day of …… 20……

……

Signature of Compliant

Note: Attach brief if necessary.

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

PRESCRIBED FEES

1. Membership

	Fee Units	
	Initial	*Replacement*
Membership Card	Not Applicable	100.00

2. Accreditation of health care providers

Category	*Fee Units*
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

No.	*Category*	*Payment Mechanism*	*Rate*	*Frequency*	*Deadline*
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 heath 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)

S/N	*Category*	*Frequency*	*Deadline*
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

DR. C. CHILUFYA,
Minister of Health

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