

NATIONAL HEALTH INSURANCE REGULATIONS, 2004 (LI 1809).

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IN exercise of the powers conferred on the Minister for Health under section 103 of the National Health Insurance Act 2003 (Act 650) and on the advice of the National Health Insurance Council, these Regulations are made this 14th day of September, 2004.

PART I—REGISTRATION AND OPERATION OF SCHEMES

Regulation 1—Application of Part I

This Part applies to all health insurance schemes licensed under the Act.

Regulation 2—Application for registration as a scheme

Application for registration as a scheme shall be as in Form I provided in Schedule I to these Regulations and shall be accompanied with the constitution, bye-laws or other rules intended to govern the operation of the scheme as specified in section 13 of the Act.

Regulation 3—Contents of constitution bye laws or rules of a scheme

- (1) The constitution, bye-laws or rules referred to in regulation 2 shall provide among others for the following:
 - (a) the conditions required for membership;
 - (b) the benefit attached to membership;
 - (c) the conditions upon which dependants of a member may participate in the scheme and the number of dependants permitted on the membership of one person;
 - (d) the giving of advance notice to members of any change in contribution, membership fee or other subscription or any other condition that affects membership;
 - (e) that the scheme is a body corporate capable of suing and being sued;
 - (f) the method of appointment or election of the governing board of the scheme;
 - (g) the method of appointment of the principal officer or manager of the scheme;
 - (h) the appointment of the auditor for the scheme and the duration of the appointment;
 - (i) the manner of calling the annual general meeting and special or extraordinary meeting of members, the quorum of meetings and the manner of voting;
 - (j) the method for ratification of decisions of the governing board by the members; and
 - (k) the method for the amendment of the constitution, bye-laws or other rules that govern the scheme.
- (2) A scheme shall give written notice to the Council of any amendment to its constitution, bye-laws or rules within thirty days of the date of the adoption of the amendment by the members.
- (3) The notice shall be accompanied with a copy of the amendment certified by the chairperson of the governing body of the scheme.

Regulation 4—Further conditions for licence

- (1) For the purposes of section 15 of the Act, the Council may require an applicant to produce a

business plan for the proposed scheme.

- (2) A business plan shall provide for a projected annual balance sheet and projected annual income and expenditure for the first two years of operation and after that period the plan shall be for such period as the Council shall in writing direct.

Regulation 5—Time for registration and licensing

The Council shall unless there is delay or default on the part of an applicant register and issue a licence for the operation of the scheme within sixty days of receipt of the application.

Regulation 6—Duration and renewal of licence

- (1) A licence to operate a scheme expires two years from the date of issue of the licence.
- (2) The licence may on an application be renewed for periods of two years at a time.
- (3) An application for renewal must be made not later than three months before the expiry of the licence.

Regulation 7—Fees for licence

- (1) The following fees shall be paid for the initial licence:
 - (a) district and private mutual health insurance schemes, two million cedis.
 - (b) private commercial health insurance scheme, ten million cedis.
- (2) The following fees shall be paid for the renewal of a licence:
 - (a) district and private mutual health insurance schemes, one million cedis;
 - (b) private commercial health insurance scheme, five million cedis.

Regulation 8—Register of schemes

- (1) The Council shall establish and maintain a register of licensed schemes in a form determined by the Council.
- (2) The register shall contain the following:
 - (a) the name and address of the scheme and whether it is a district mutual, private mutual or a private commercial scheme;
 - (b) the date of registration of the scheme; and
 - (c) such other particulars as the Council shall determine.
- (3) The register is a public document and any member of the public may inspect the register without payment of a fee except that there shall be a fee determined by the Council for extract from the register.

Regulation 9—Interim management of a scheme

- (1) Where the Council decides to put a scheme under an interim management team for the purposes of section 2 of the Act, the Council shall in writing direct the governing body of the scheme to convene a special meeting of its members presided over by the chairperson of the Council or such person as the Council shall determine not later than thirty days after the date of the issue of the directions.
- (2) The agenda for the special meeting shall be as follows:
 - (a) that the governing board of the scheme be dissolved; and
 - (b) that an interim management team be appointed to exercise the powers of the manager or principal officer of the scheme for a period not exceeding twelve months.

- (3) The board shall be informed of the reasons for the Council so acting and be given an opportunity to be heard except that the Council need not give the board the opportunity if in its opinion the opportunity would enable the board or any other person to dispose of any assets of the defaulting scheme or take any other action that would be prejudicial to the members or creditors of the scheme.
- (4) Where after the notification to call a special meeting the board fails to do so the Council shall immediately cause a publication to be made in the Gazette and the media calling a general meeting of the members of the defaulting scheme and inform the members of the intention of the Council to place the scheme under an interim management team.

Regulation 10—Transfer of business of a scheme to another scheme

- (1) Where an interim manager reports in writing to the Council that in its opinion there is no reasonable prospects of restoring the defaulting scheme to sound financial conditions and the interim manager in consultation with the auditors of the defaulting scheme recommends the revocation of the registration of the scheme or the transfer of its business or activities to another scheme, the Council may act accordingly.
- (2) For the purposes of subregulation (1) where transfer of the business or activities of a defaulting scheme is made, the transferee shall,
 - (a) in exchange for the assets of the defaulting scheme, take such liabilities of that scheme as the transferee and the transferor shall agree with the approval of the Council, including liabilities to health-care providers and members under claims which have been submitted and assessed but not yet paid as at a date (in this regulation called "the cut-off date") not earlier than three months before the date on which the Council approved the transfer, but not including,
 - (i) contingent liabilities in respect of members of the defaulting scheme which may accrue after the cut-off date; or
 - (ii) liabilities for which an officer of the defaulting scheme may be held personally liable because of fraudulent conduct or any other cause;
 - (b) undertake to admit every member of the defaulting scheme who is a duly enrolled member on the date of the transfer and is qualified to receive the minimum benefit under the defaulting scheme;
 - (c) waive any waiting period in relation to a member of the transferring scheme who qualifies to receive benefits under the transferring scheme and count any portion of the waiting period served by a member of the transferring scheme as part of the waiting period of the scheme to which the member is being transferred.
- (3) Upon the conclusion of a transfer under this regulation, the Council shall issue a publication in the Gazette and the media of the transfer.

Regulation 11—Management of a scheme

- (1) Every scheme shall in accordance with section 54(1) of the Act have a governing body referred to in these Regulations as the board.
- (2) Every scheme shall determine the size of its governing body except that in the case of a district mutual health scheme, the membership of the body shall not be less than seven members and not more than fifteen members of whom at least two should be women.
- (3) Where for the purposes of section 54(3) of the Act, a scheme is managed by an independent body corporate, a copy of the agreement between the scheme and the body corporate

appointing the body as the scheme manager shall be submitted to the Council by the chairperson of the governing body within thirty days of the date of the signing of the agreement.

- (4) Where the chairperson of the governing body of a scheme fails to submit the copy of the agreement within the time stipulated in subregulation (4) the Council may impose such pecuniary or other penalty as it considers appropriate.
- (5) A member of the governing body of a scheme who has an interest in a matter before the body shall disclose the interest to the body and shall not participate in a discussion of the matter.
- (6) A scheme manager or principal officer shall keep in separate accounts, monies for payment of claims and monies required to meet the administrative expenses of the scheme.
- (7) The monies for administrative expenses shall not exceed twenty per cent of the total funds of the scheme unless the Council otherwise directs in writing.
- (8) The manager or principal officer of a scheme is responsible to the board of the scheme in the management of the scheme, in particular financial matters.
- (9) A scheme manager that acts contrary to subregulation (7) or (8) commits an offence and is liable on summary conviction to a fine not exceeding 1000 penalty units.

Regulation 12—Qualification of a board member of a scheme

A person does not qualify to be a member of a governing body of a scheme unless he has not under the laws of this country or any other country

- (a) been adjudged or otherwise declared insolvent or bankrupt without being discharged;
- (b) made an assignment to, arrangement or composition with creditors which has not been rescinded or set aside;
- (c) been convicted of an offence involving corruption, fraud or dishonesty; or
- (d) been found liable for misconduct or mismanagement while in any employment.

Regulation 13—Qualification of manager or principal officer of a scheme

- (1) The governing body of every scheme shall in accordance with section 54(2) of the Act appoint a manager or principal officer for the scheme who shall

- (a) in the case of a corporate manager, be approved by the Council;
- (b) in the case of an individual, be a person who holds at least
 - (i) HND in Accounting, Marketing or Statistics; or
 - (ii) a professional qualification in administration, finance or insurance

and has reasonable experience in administration.

- (2) Every scheme shall in addition to a manager have the following other officers:

- (a) an Information Systems manager, who shall be a person who holds a Bsc degree or an HND in Computer Science and who has at least one year experience in Information Systems Management;
- (b) a claims manager;
- (c) a marketing or public relations officer;
- (d) an accountant, who shall be a person who holds a Bsc degree or an HND in accounting or an intermediate certificate of any nationally recognised professional accounting body and

- who has at least one year experience in accounting practice.
- (3) An officer shall apart from the academic or professional qualification
- (a) be a person of a high moral standing,
 - (b) not be a member of the board of any other scheme; and
 - (c) not under the laws of this country or any other country,
 - (i) been adjudged or otherwise declared insolvent or bankrupt without being discharged;
 - (ii) made an assignment to, arrangement or composition with creditors which has not been rescinded or set aside;
 - (iii) been convicted of an offence involving corruption, fraud or dishonesty; or
 - (iv) been found liable for misconduct or mismanagement while in any employment.
- (4) Notwithstanding subregulations (1) and (2) a scheme may with the approval of the Council employ such number of officers and officers with lesser qualification than prescribed as its governing body may determine.
- (5) The provisions of this regulation is without prejudice to the qualification required of principal officers of a private commercial health insurance scheme as provided under section 45(1)(f) of the Act.

Regulation 14—Report on disqualified Officers

- (1) Where the Council receives information or a complaint that a director, principal officer or manager of a scheme has ceased to be qualified, the Council must immediately direct an investigation of the complaint by,
- (a) furnishing the board of the scheme and the officer with details of the information or complaint; and
 - (b) requiring the officer to make a written representation to the board of the scheme within thirty days of the date of the request.
- (2) The board of the scheme must after the investigation and considering the representations of the officer, take such action as it considers appropriate and inform the Council accordingly

Regulation 15—Investigation of officers of scheme

- (1) If the scheme to which a complaint has been referred by the Council under regulation 14(1) fails or refuses to investigate the matter, the Council shall investigate the matter and direct the scheme to comply with the decision of the Council on the matter.
- (2) The cost of the investigation under subregulation (1) shall be borne by the scheme and the Council may impose such pecuniary penalty for the default as the Council considers appropriate in the circumstances.

Regulation 16—Prohibition of discrimination

- (1) A scheme shall not with respect to the admission of persons as members of the scheme or as between its members in the same class of the scheme, discriminate against any person on the basis of race, sex, disability, marital status, ethnic, social origin, nationality, religion or creed,
- (a) by subjecting the person to a condition, restriction or disability to which persons of the same class are not subjected to; or
 - (b) by conferring on persons in the same class, a privilege or advantage which is not

conferred on persons in the same class.

- (2) A scheme that contravenes any provision in subsection (1) shall be required by the Council to pay such pecuniary penalty as the Council considers appropriate and if the scheme fails to pay the pecuniary penalty the Council may revoke the licence of the scheme.

Regulation 17—Prohibition of differences in tariff for the same service

There shall be no discrimination in the amount of tariff at the point of rendering a healthcare service in the same healthcare facility.

Regulation 18—Health insurance identity card

- (1) The Health ID Card provided for under section 65 of the Act shall
- (a) be issued to a member within six months of the registration of the member by the scheme;
 - (b) have a unique number specific to the member;
 - (c) contain a picture of the member; and
 - (d) state the address, age and such other particulars as the Council may direct.
- (2) Upon the loss of a Health ID Card, the scheme shall replace the card upon payment of a fee determined by the scheme.

Regulation 19—Minimum benefits to members under health insurance scheme and free public health care Services

- (1) For the purposes of section 64 of the Act, the minimum health care benefits set out in Part 1 of Schedule II to these Regulations shall be available to members registered with a scheme licensed under the Act.
- (2) A scheme may despite subregulation (1) provide for its members health care services over and above the minimum benefits specified in Part I of Schedule II subject to the payment of such additional premium as is agreed upon by the scheme and the members; and for this purpose the scheme is not required to adhere to the National Insurance Drug List.
- (3) A district mutual health insurance scheme shall not provide the healthcare services over and above the minimum specified in Part I of Schedule II unless it has the prior approval of the Council.
- (4) The public health care services specified in Part 3 of Schedule II shall be paid for by Government and shall be free. Part 1 Part 2 Part 3

Regulation 20—Excluded health care services

The healthcare services set out in Part 2 of Schedule II do not fall within the minimum health care benefit available under the national health insurance scheme.

Regulation 21—Suspension of and discontinuation of benefit to a member

- (1) A scheme may suspend a member and discontinue the benefit to which the member is entitled on any of the following grounds only:
- (a) failure by the member to pay the member's contribution within the stipulated period in the constitution, bye-laws or rules of the scheme;
 - (b) failure to pay any debt due to the scheme in respect of the member;
 - (c) submission of a fraudulent claim with the knowledge or support of the member;
 - (d) commission of any act of fraud or dishonesty in relation to the scheme; or

- (e) non-disclosure of any material information requested by the scheme.
- (2) Where a scheme suspends a member under subregulation (1) the scheme shall give at least seven days notice of the suspension to the healthcare facilities of the scheme.

Regulation 22—Accreditation of health care facilities

- (1) The following health care service facilities may be accredited by the Council to operate under the national health insurance scheme:
 - (a) teaching hospitals;
 - (b) regional hospitals;
 - (c) district hospitals;
 - (d) quasi public hospitals, (such as the Military, Police, University, and Social Security and National Insurance Trust hospitals);
 - (e) health centres;
 - (f) dental clinics;
 - (g) private hospitals and health clinics;
 - (h) maternity homes;
 - (i) mission hospitals,
 - (j) pharmacies and licensed chemical sellers facilities;
 - (k) private medical diagnostic facilities and
 - (l) such other facilities as the Council may determine.
- (2) For purposes of accreditation under these Regulations, the Council may seek and rely on information from relevant regulatory bodies and such other institutions as it considers appropriate.

Regulation 23—Qualification for accreditation of a health care facility

The following is required of a healthcare facility before accreditation:

- (a) the facility must have been operating for at least six months immediately before the date of the initial application for accreditation;
- (b) the facility must have a good record in the provision of health care services over the period specified in paragraph (a);
- (c) the facility must have the human resources, equipment, physical structures and other requirements that meet the standards of the Council;
- (d) the facility must accept the quality assurance standards and utilization review of the Council and the payment mechanism approved by the Council;
- (e) the facility must adopt the referral protocols, practice guidelines and health resource sharing arrangements of the schemes as approved by the Council;
- (f) the facility must have its own formal quality assurance programme;
- (g) the facility must recognise and respect the rights of its patients or customers;
- (h) the facility must accept to comply with the information system requirements and regular transfer of information, including any reporting mechanism established by the Council and the schemes to which it is accredited;
- (i) the facility must maintain accurate records of

- (i) its patients or customers;
- (ii) services rendered;
- (iii) results from the services; and
- (iv) health expenditure on patients or customer care as is appropriate;
- (j) the facility must be willing and able to comply with all corrective actions directed by the Council for the purpose of ensuring quality health service; and
- (k) the facility must agree to permit the Council or any person authorised by the Council to
 - (i) enter and inspect its premises and health facilities; and
 - (ii) have access to inspect its medical, financial and other records relevant to health insurance

Regulation 24—Specific accreditation requirements for hospitals

Hospitals and ambulatory surgical clinics in addition to the requirements under regulation 23 as a further condition for their accreditation under the Act,

- (a) must have been approved by the Ministry of health;
- (b) shall comply with
 - (i) the provisions of the Private Hospitals and Maternity Homes Act, 1958 (No.9) as amended and Regulations made under that Act; and
 - (ii) the Ministry of health's approved guidelines for ambulatory surgical clinics as well as other administrative orders of the Ministry in the case of ambulatory surgical clinics;
- (c) shall be a member of good standing of any national association of licensed hospitals in the country, and
- (d) shall have a quality assurance programme.

Regulation 25—Specific accreditation requirements for community based health planning and services

Community based health planning and services shall in addition to the requirements for accreditation under regulation 23,

- (a) be organised or managed by members of the community for the purpose of improving the health status of the community through preventive, promotive and curative health services;
- (b) be affiliated to at least one health care facility accredited by the Council, or have facilities that are necessary to provide for health services for its beneficiaries as the Council may determine; and
- (c) have a quality assurance programme.

Regulation 26—Specific accreditation requirements in respect of health professionals

Every health professional working in a health care facility that seeks accreditation shall,

- (a) be duly licensed to practise the relevant profession in Ghana by the appropriate regulatory body of the profession;
- (b) be a member in good standing of the relevant national association of the profession;
- (c) abide by the Code of Ethics of the profession; and
- (d) observe the practice guidelines or protocols, peer review and payment mechanisms of the scheme.

Regulation 27—Other matters relating to accreditation of health care facilities

- (1) The Council shall publish in the Gazette and a news paper that has national circulation the list of documents that shall be submitted and the conditions that are required for accreditation.
- (2) The Council may subject the documents submitted for the purpose of accreditation under subregulation (1) to verification and authentication.
- (3) Initial accreditation is for a period of five years and after that period is renewable every two years and may be revoked or suspended after the Council has given notice to the affected party and granted that party a hearing.
- (4) In granting accreditation, the Council shall take into consideration the installed capacity in terms of equipment and services available to the health facility and may impose limitations on the services to be provided by the facility.
- (5) Accreditation shall operate prospectively and shall not take effect until the issue of the certificate of accreditation.
- (6) A claim by a health facility for services rendered before the issue of a certificate of accreditation to that provider is invalid.

Regulation 28—Application for accreditation

- (1) Application for accreditation shall be made to the Council and shall be as in Form 2 in Schedule I.
- (2) The application for accreditation shall be accompanied with the accreditation fees and any document required for the accreditation.
- (3) The Council shall within fourteen days after the receipt of the application cause to be conducted
 - (a) verification of compliance with the requirement, and authenticity of the documents submitted; and
 - (b) inspection of the facilities.
- (4) A verification and inspection report shall be prepared for and submitted to the Council within sixty days of the receipt of the application by the Council.
- (5) The Council shall make a decision on the application and inform the applicant of that decision in writing within ninety days of receipt of the application.
- (6) Where the Council is satisfied that all the requirements for accreditation have been met by the applicant and the accreditation fee has also been paid, the Council shall grant accreditation to the applicant.

Regulation 29—Denial of accreditation

- (1) Accreditation may be denied by the Council on any of the following grounds:
 - (a) non-compliance with any of the requirements and conditions of accreditation;
 - (b) revocation, non-renewal or non-issuance of licence to operate or practise as a health care facility by the relevant regulatory authority;
 - (c) fraud;
 - (d) change in the ownership of a health care facility for the purpose of evading the consequences of impropriety or violations of requirement or conditions previously committed;
 - (e) non-compliance with any safeguards provided under the Act or these Regulations;

- (f) such other grounds as the Council may determine.
- (2) An applicant who is denied accreditation may apply for a review of the decision under regulation 34.

Regulation 30—Accreditation certificate

- (1) An accredited health facility shall be issued an accreditation certificate by the Council which shall be as in Form 3 in Schedule I.
- (2) The accreditation certificate shall
 - (a) contain an accreditation number, which shall serve as the identification number for the purpose of the information systems of the schemes;
 - (b) state the grading of the facility; and
 - (c) be prominently and conspicuously displayed in the facility's office or place of practice.
- (3) An accreditation certificate shall be surrendered by the holder to the Council upon suspension or revocation of the accreditation.
- (4) An accredited health care facility shall display in a prominent and conspicuous manner a sign to the effect that the facility is accredited by the Council.
- (5) The sign mentioned under subregulation (3) shall also be placed outside the facility and next to the facility's name.
- (6) The Council may place a sign outside a facility and next to the facility's name indicating the suspension or revocation of accreditation of the facility.

Regulation 31—Suspension or revocation of accreditation of a healthcare facility

- (1) The Council may suspend or revoke an accreditation granted to a health care facility if the Council is satisfied that the facility has
 - (a) failed to comply with any of the requirements and conditions of the accreditation;
 - (b) lost its licence to operate;
 - (c) been convicted of fraud; or
 - (d) been convicted of any offence under the Act or under these Regulations.
- (2) Where the Council decides to suspend or revoke an accreditation, the Council shall within fourteen days of making that decision, give notice of the decision to the affected health care facility and give a hearing to that facility within thirty days after the notice.
- (3) Where an accreditation is suspended the Council shall in the notice under subregulation (2) inform the health care facility of the acts or omissions that have occasioned the suspension and give the facility reasonable time to remedy the wrong.
- (4) A person dissatisfied with the decision of the Council to suspend or revoke an accreditation may apply for review under regulation 44, 45 and 46 but shall do so not more than sixty days after the date he or she becomes aware of the decision.
- (5) The Council shall reinstate a suspended accreditation where it is satisfied that the act or omission which gave rise to the suspension has been remedied by the healthcare facility within the time given by the Council.
- (6) Where an accredited health care facility fails to remedy the defects which gave rise to the suspension, within the time specified, the Council shall revoke the accreditation.

- (7) Where the Council suspends the accreditation of a facility, the Council shall within seven days of the suspension, give public notice of the suspension in such manner as the Council shall determine.

Regulation 32—Renewal of accreditation

- (1) An application for renewal of accreditation shall be submitted to the Council not later than six months prior to the expiration of the previous accreditation.
- (2) The application for renewal shall be in such form and be accompanied with such documents and fees as the Council shall determine.
- (3) The accreditation of a health care facility against whom allegations of impropriety are pending shall not be renewed until investigations have been conducted and the facility is absolved of any impropriety.
- (4) Where there are adverse findings against the facility, the renewal of accreditation shall be denied.
- (5) The accreditation of a facility whose accreditation is suspended shall not be renewed until the suspension has been lifted.

Regulation 33—Re-accreditation of health care facility

- (1) A healthcare facility whose previous accreditation had lapsed or whose application was denied may apply for reaccreditation.
- (2) A health care facility which changes ownership, shall apply for reaccreditation.
- (3) Where accreditation lapses because of a health care facility's effort to evade the consequences of a previous violation or adverse findings of impropriety, the application for re-accreditation shall be treated as an application for an initial accreditation.
- (4) A health care facility that upgrades or downgrades its facilities shall apply for re-accreditation.

Regulation 34—Review of accreditation

An accreditation is subject to such review as the Council may determine.

Regulation 35—Performance monitoring of health care facilities

- (1) The Council in consultation with the schemes shall develop and implement a performance monitoring system of accredited health care facilities.
- (2) Any monitoring system shall safeguard against,
 - (a) gross or unjustifiable deviation from current accepted standards of practice or treatment method;
 - (b) use of fake, adulterated or substandard pharmaceuticals or unregistered drugs;
 - (c) except as provided under regulation 19(2) and for private mutual and commercial health insurance schemes, use of drugs other than those on the National Health Insurance Drug List.

Regulation 36—Method of monitoring performance

- (1) The monitoring system shall be carried out, among others through
 - (a) periodic inspections of health facilities and other offices;
 - (b) collection of data from health care services rendered by health care facilities;

- (c) periodic review of collected data to determine the quality, cost and effectiveness of service and adherence to accepted and known standards of health care practice;
 - (d) peer review; and
 - (e) a mandatory reporting mechanism approved by the Council.
- (2) For the purposes of monitoring the performance of health care facilities, every accredited facility shall submit a quarterly report to the Council which shall include the following data for the quarter:
- (a) patients attended to, classifying them into out patients and admitted (in-patients) patients as is applicable;
 - (b) bed occupancy;
 - (c) average length of admission of patients;
 - (d) mortality rate;
 - (e) five most common causes of admission;
 - (f) ten most common causes of Out-Patients Department (OPD) attendance
 - (g) types and the number of minor and major operations performed; and
 - (h) non-paying members of insurance schemes that were attended to.
- (3) For the purposes of monitoring the performance of pharmaceutical service providers, every accredited pharmaceutical service facility shall submit a quarterly report to the Council, which shall include the following:
- (a) number of patients on the scheme attending the facility;
 - (b) number of patients attending the facility outside the scheme;
 - (c) number of prescriptions served
 - (i) fully,
 - (ii) partially,
 - (iii) unable to serve;
 - (d) interventions made and total cost saved for the scheme from non dispensing of irrational or invalid prescriptions,
 - (e) top most five drugs dispensed; and
 - (f) number and type of extemporaneous preparations made.

Regulation 37—Payment of tariffs to health care facilities

- (1) In determining the tariffs to be paid to health care facilities and the schemes, the Council shall consult the facilities and the schemes.
- (2) Payment for health care services rendered by a health care facility shall be made by either of the following systems:
- (a) capitation;
 - (b) fee-for-service; or
 - (c) any other payment system that the Council may determine.
- (3) Capitation means a payment mechanism in a written agreement by which a fixed rate of

payment for a fixed period is negotiated with an accredited health care facility to deliver health care services to a person, family, household or a group of persons covered under the terms of the agreement for health insurance services.

- (4) For a fee-for-service payment the health care facility and the attending health care personnel shall file the claim in the Form 4 provided in Schedule I.
- (5) Hospitals shall attach Forms 4, 5, and 6 in Schedule I to the clinical records of a patient upon admission.
- (6) In the event of admission, the patient shall not be discharged unless the attending medical practitioner and the patient sign or thumbprint the forms provided for under subregulation (4).
- (7) A claim for payment of health care services rendered under a scheme licensed under this Act shall be filed within sixty calendar days from the date of the discharge of the patient or the rendering of the service.
- (8) Except as provided under regulation 54 in respect of district mutual health insurance schemes or except in the case of an emergency, a claim for payment not made within the stipulated period is barred upon the expiry of the period stated in subregulation (7).

Regulation 38—Time for payment claims by schemes

- (1) A claim for payment of health care service rendered which is submitted to a scheme shall, unless there is any legal impediment, be paid by the scheme within four weeks after the receipt of the claim from the health care facility.
- (2) All claims shall be paid directly to the health care facility and on no account shall direct payment be made to a patient.

Regulation 39—Power of scheme to refuse or reduce claim

- (1) A scheme may deny or reduce the payment of tariff claimed by a health care facility where the management of the scheme is satisfied that the claim is attended by any or all of the following
 - (a) over-servicing of the patient by the health care facility as determined through peer review;
 - (b) unnecessary diagnostic and therapeutic procedures and intervention, as determined through peer review;
 - (c) irrational medication and prescriptions as determined through peer review;
 - (d) fraud;
 - (e) gross and unjustified deviations from current accepted standards of practice or treatment protocols or both;
 - (f) inappropriate referral practices;
 - (g) provision of services other than those for which accreditation has been granted;
 - (h) use of fake, adulterated or substandard pharmaceuticals,
 - (i) in the case of district mutual health insurance scheme, use of drugs other than those provided in the National Health Insurance Drug List and traditional medicines approved by the Food and Drugs Board;
 - (j) false or incorrect information; or
 - (k) the failure of the healthcare facility without justifiable cause to comply with agreement between the scheme and the health facility.

- (2) Where a claim is refused or reduced, the amount that is refused or reduced shall not be charged directly or indirectly to the beneficiary involved.
- (3) The outcome of a peer review conducted by a professional organization or a health care facility without the authority or consent of the scheme shall not bind the scheme with respect to payment of claims.
- (4) When a claim filed by a hospital with a scheme indicates that bed occupancy rate of the health care facility exceeds its accredited bed capacity, the claim shall be accompanied by a written justification.
- (5) Any operation performed beyond the authorized capability of the health care facility shall be considered a violation, and a claim for the operation shall be denied by the scheme, except where the operation is done in an emergency or where referral to higher category health care facility is impossible.

Regulation 40—Intervention by service providers in respect of prescription

Where a healthcare provider considers a prescription or medication irrational or inappropriate in the circumstances, the health care facility may after prior consultation with the prescriber intervene and, provide an appropriate medication and make a report to the scheme.

Regulation 41—Re-imburement for drugs

- (1) The Council shall in consultation with the Ministry of Health and the Pharmacy Council determine the quarterly price indices of drugs and medicines on the National Health Insurance Drug List and for which re-imburement is to be paid by the schemes.
- (2) Based on the quarterly indices, the Council shall in consultation with pharmaceutical service providers regularly set allowable percentage mark-up in the prices of drugs and medicines charged by health care facilities and re-imburement shall only be made for drugs and medicines within the allowable mark-up price.

Regulation 42—Particulars of drugs and medicines

- (1) In order to support a claim for drugs or medicines supplied to a beneficiary under a scheme licensed under the Act, the health care facility shall specify the generic name of each drug or medicine administered to the beneficiary.
- (2) Form 5 in Schedule I shall be used with appropriate modification.

Regulation 43—Complaint settlement procedure of schemes

- (1) A scheme shall maintain a register into which shall be recorded every complaint received from a member or a health care facility
- (2) A scheme shall provide for
 - (a) the manner in which complaints are to be made;
 - (b) the person or authority to whom a complaint should be made;
 - (c) the time within which the complaint should be submitted following the occurrence of the cause of the complaint which shall in any event not exceed fourteen days;
 - (d) the time within which a complaint is to be dealt with, which time should be reasonable and in any event not be more than two months from the date the complaint was lodged with the scheme; and
 - (e) the person who deals with complaints.
- (3) A complaint may be submitted as in Form 10.

- (4) The scheme shall investigate all complaints recorded in an expeditious manner and take appropriate steps to settle the complaint.
- (5) A scheme shall provide in writing the remedies available to complainants under this regulation and the right of a complainant to refer the complaint to the district Health Complaint Committee established under section 8 of the Act where the person is dissatisfied with action taken by the scheme or the failure by the scheme to attend to the complainant within the time required under subregulation (1) (d).

Regulation 44—Reference of complaint to the district health complaint committee

- (1) If a complaint is not settled to the satisfaction of the complainant within two months of the date of the receipt of the complaint by the manager, the manager shall make a written report to the District Health Complaint Committee of the details of the complaint and the action taken in respect of the complaint within thirty days from the date of inability to settle the complaint and inform the complainant of the reference to the District Health Complaint Committee.
- (2) Nothing in subregulation (1) prevents the complainant from referring the unsettled complaint to the District Health Complaint Committee after the expiration of sixty days.

Regulation 45—Complaint settlement procedure of District Health Complaint Committee

- (1) For the purposes of section 8(4) and (5) of the Act a health care facility or a member of a scheme who desires the settlement of a complaint shall submit the complaint to the relevant District Health Complaint Committee, except that a complaint from a health care facility or a member of a scheme shall not be entertained by the District Health Complaint Committee unless reference for settlement was first made to the scheme.
- (2) The complaint shall be supported with a written record that the complaint was first submitted to the scheme concerned for action and there has been failure to settle the complaint within the stipulated time under these Regulations or there is failure to settle it to the satisfaction of the complainant.
- (3) Despite subregulations (1) and (2), complaint of a scheme against another scheme or its member or healthcare facility shall be submitted to the District Health Complaint Committee and shall be in writing.
- (4) The District Health Complaint Committee shall within seven days of receipt of the complaint cause a copy of the complaint to be sent to the person against whom the complaint is made.
- (5) The person against whom the complaint is made shall within five working days from the date of the receipt of the complaint or such further period as the Committee may permit submit a response to the complaint to the Committee.
- (6) The District Health Complaint Committee shall investigate the complaint and invite the parties for a settlement of the complaint.
- (7) A District Health Complaint Committee shall in its deliberations be guided by the rules of natural justice.

Regulation 46—Time of decision and review

- (1) A District Health Complaint Committee shall give its decision on any complaint before it within thirty days of receipt of the complaint.
- (2) A party to any dispute for settlement who is dissatisfied with the decision of a District Health

Complaint Committee may apply to the Council within fourteen days of the decision for a review of the decision of the Committee.

Regulation 47—Records of complaint

- (1) A scheme shall keep records of each complaint made to it and the manner it is dealt with.
- (2) The records shall be kept for not less than twelve months from the date the records are made and shall be made available to the Council as part of its annual report to the Council.
- (3) The Council may despite subregulation(2) at any time request a scheme to make its complaints records available for inspection.

Regulation 48—Accounts

- (1) Every scheme shall keep proper accounting records and the accounting records of a scheme shall be in a form approved by its auditors.
- (2) A scheme shall ensure that,
 - (a) moneys received are promptly paid into its accounts;
 - (b) payments out of its moneys are correctly made and properly authorised; and
 - (c) adequate control is maintained over its assets and over the incurring of liabilities by the scheme.
- (3) The accounting records kept under subregulation (1) shall,
 - (a) be sufficient to record and explain the scheme's transactions;
 - (b) enable its financial position to be determined with reasonable accuracy at anytime; and
 - (c) be sufficient to enable financial statements to be prepared and audited in accordance with this regulation.
- (4) Within three months after the end of each financial year, a scheme shall prepare accounts containing,
 - (a) a statement of the assets and liabilities of the scheme at the end of the preceding financial year;
 - (b) a statement of the revenue and expenditure of the scheme during the financial year;
 - (c) proper and adequate explanatory notes to the financial statements; and
 - (d) such other matters as the Council may in writing direct.

Regulation 49—Audit

- (1) The board of a scheme shall annually appoint the auditors for the scheme and agree on the fee payable to the auditor.
- (2) An auditor shall not be an employee, manager, director or principal officer of the scheme.

Regulation 50—Duties and power of auditors

- (1) The auditor of a scheme shall
 - (a) audit the scheme's accounts and report on its balance sheet and income and expenditure account;
 - (b) scrutinise and carry out audit procedures designed to detect irregularities and illegal acts in the conduct of the activities or business of the scheme;
 - (c) communicate to the board of the scheme any evidence of irregularities or illegal acts

- committed in the course of the scheme's business or activities whether or not they may have led to material misstatements in the scheme's account or records, and
- (d) communicate to the Council any evidence the auditor may have that irregularities or illegal acts have been committed by
 - (i) any officer or employee of the scheme; or
 - (ii) any other person, if there is a reasonable possibility that they may significantly damage the scheme's financial stability.
 - (2) In every report referred to in paragraph (a) of subregulation (1) the auditor shall state whether the accounts of the scheme fairly present the state of affairs and the activities or affairs of the scheme.
 - (3) The report of the auditor shall record,
 - (a) any irregularity or illegal act which the auditor has ascertained, or which he or she suspects, has occurred in relation to the conduct of the business or activities of the scheme;
 - (b) any other matter which, in the auditor's opinion, requires rectification or attention by the scheme; and
 - (c) any recommendations for improving the scheme's financial administration,and a copy of the report shall immediately after the audit be submitted to the Council.
 - (4) In addition to the report required under this regulation, the Council may request an auditor of a scheme to submit such other reports as the Council considers necessary.
 - (5) The Council may appoint an auditor for a scheme if the board of that scheme fails to appoint an auditor, and the auditor shall be deemed to have been appointed by the scheme.
 - (6) The auditor of a scheme shall comply with his or her obligations under this regulation
 - (a) to submit reports or to include information in reports;
 - (b) to provide information notwithstanding any duty of confidentiality to the contrary, and shall not be held liable in any proceedings arising out of compliance with any obligation unless it is proved that he or she acted in bad faith.
 - (7) An auditor of a scheme shall,
 - (a) have a right of access at all reasonable times to the scheme's books and accounts; and
 - (b) be entitled to require such information and explanations from any officer, employee or agent of the scheme, as in his or her opinion, is required in order to enable him or her to perform his or her duties as an auditor.
 - (8) Any person who fails without just cause
 - (a) to permit an auditor to have the access referred to in paragraph (a) of subregulation (7); or
 - (b) to comply with a requirement to submit information or offer an explanation under paragraph (b) of subregulation (7)commits an offence and is liable on summary conviction to a fine not exceeding 250 penalty units or to a term of imprisonment not exceeding six months or to both.

Regulation 51—Annual report to the Council

- (1) For the purposes of the Act the Council shall determine the form of the annual report required to be submitted by a scheme under section 57(2) of the Act.
- (2) The annual report shall cover the period starting from 1st January and ending on 31st

December.

PART II—DISTRICT MUTUAL HEALTH INSURANCE SCHEMES- ADDITIONAL PROVISIONS

Regulation 52—Location of Headquarters of District Schemes

The headquarters of a District Mutual Health Insurance Scheme shall as far as practicable be located in a town in the district that has at least electricity and telephone facilities.

Regulation 53—Minimum membership of a scheme

- (1) A district mutual health scheme shall have at least two thousand members before it is registered by the Council.
- (2) Despite subregulation (1), a proposed scheme with less than the number of members provided under subregulation (1) may be registered on condition that the membership will within two years from the date of registration increase to the minimum required under subregulation (1).
- (3) A scheme shall for the purposes of subregulation (2) render every six months, namely 30th June and 31st December of each year, a return on its membership to the Council.
- (4) Where a scheme fails to make the minimum membership by the end of the two years, the Council may revoke the licence of the scheme and recommend appropriate arrangement to meet the healthcare needs of the members.

Regulation 54—Application for membership of District Scheme

- (1) The process of application for membership of a District Mutual Health Insurance Scheme shall be as determined by the scheme.
- (2) Notwithstanding subregulation (1) an application may be as in Form 11 in Schedule 1.

Regulation 55—Mode and time of payment of contribution

- (1) The mode and time of payment of contribution shall be determined by each scheme,
- (2) The provisions in subregulation (1) are subject to section 34 subsections (4) and (5) of the Act.
- (3) A scheme may employ any method it finds effective for the payment of contribution by its members.

Regulation 56—Exemption from payment of contribution on basis of age

A person who is

- (a) under eighteen years of age and both of whose parents or guardians are contributors;
- (b) under eighteen years of age and whose parent or guardian has been proven by the scheme to be a single parent or guardian;
- (c) a pensioner under the SSNIT Scheme; or
- (d) seventy years or over seventy years of age

is not required to pay any contribution to a District Mutual Health Insurance Scheme but is entitled in the case of a child to enjoy the minimum benefits under the scheme as a dependant, and in the case of a person of seventy years of age or above to enjoy the minimum benefit under the scheme in which the person is a member in that person's own right.

Regulation 57—Participation in District Scheme by a dependent

Notwithstanding Regulation 55 a dependant of a contributor who is

- (a) not a child;

- (b) a pensioner under the SSNIT Scheme; or
 - (c) a person of seventy years or above seventy years
- may in accordance with section 56 of the Act and in accordance with the constitution of a District scheme, participate in the district scheme and receive the same minimum benefits that are available under the district scheme subject to a reasonable variation in the level of contribution by the contributor.

Regulation 58—Means test for indigent persons

- (1) A person shall not be classified as an indigent under a district scheme unless that person
 - (a) is unemployed and has no visible source of income;
 - (b) does not have a fixed place of residence according to standards determined by the scheme;
 - (c) does not live with a person who is employed and who has a fixed place of residence; and
 - (d) does not have any identifiable consistent support from another person.
- (2) The conditions under subregulation (1) for ascertaining who is an indigent shall be incorporated in the registration form of a district scheme.
- (3) A person assigned the duty by a district scheme of registering persons for the scheme, shall elicit the information required under the subregulation (1) for the classification of indigents as part of the registration process.
- (4) Every district scheme shall keep and publish a list of indigents in its area of operation and submit the list to the Council for validation.
- (5) Where the list of indigents submitted by a district scheme exceeds one-half percent of the entire membership of the scheme, the Council shall verify the list by whatever means the Council determines.
- (6) Any member of a district scheme who is dissatisfied with the classification of a person as an indigent under the scheme may first complain to the scheme and after that if the member is still not satisfied, to the District Health Complaint Committee.
- (7) The District Health Complaint Committee shall investigate any complaint about the classification of a person as an indigent.

Regulation 59—Suspension and reinstatement of a defaulting member

- (1) A member of a district scheme who, except as otherwise provided by the scheme, defaults in the payment of contribution to the scheme for a period exceeding three months shall be suspended from the scheme,
- (2) A member of a district scheme whose membership of the scheme is suspended because the member has defaulted in the payment of contributions to the scheme shall be reinstated if that member pays all the contributions in arrears and in addition pays a penalty of fifty per centum of the total contribution that is due.
- (2)ⁱ A suspended member of a district scheme who is reinstated under subregulation (1) shall not enjoy any benefits under the scheme until the expiration of a period of six months from the date of re-instatement.

PART III—PRIVATE COMMERCIAL AND PRIVATE MUTUAL HEALTH INSURANCE SCHEMES-ADDITIONAL PROVISIONS

Regulation 60—Payment of contribution to private commercial and private mutual

schemes.

The mode, time, quantum and conditions for the payment of contribution to private commercial and private mutual health insurance schemes shall be determined by the boards of the schemes.

Regulation 61—Security deposit for private commercial schemes

Every private commercial health insurance scheme, shall in accordance with section 43 of the Act, deposit with the Bank of Ghana, ₵5.5 billion

PART IV—MISCELLANEOUS

Regulation 62—Use of forms and variations in the forms

The following Forms provided in Schedule I shall be used in respect of district mutual health insurance schemes and may be used by other health insurance schemes licensed under this Act with such modifications as are considered appropriate: Form 2 Form 3

Form 4 .. In-Patient Treatment Costing Sheet

Form 5 .. Health Facility Attendance Card

Form 6 .. Diagnostic Card

Form 7 .. Prescription Form

Form 8 .. Claims Form

Form 9 .. District Mutual Health Membership/Household Registration

Form 10 .. Complaint Form

Regulation 63—Interpretation

(1) In these Regulation unless the context otherwise requires,

"**Act**" means the National Health Insurance Act, 2003 (Act 650);

"**accreditation**" has the same meaning it has in the Act;

"**beneficiary**" has the same meaning it has in the Act;

"**benefit package**" means the healthcare services that are available to a contributor or member of a health insurance scheme;

"**contribution**" has the same meaning it has in the Act;

"**Community Health Insurance and Planning Services**" means an arrangement by which members of a community establish and manage health care facilities for the benefit of members of the community and for the purpose of improving the health status of the members;

"**Council**" means the National Health Insurance Council established under section 1 of the Act;

"**fee-for-service**" means in respect of out-patient (OPD), consultation fees, costs of drugs and cost of management; and in respect of admitted patients (in patients), admission fees, costs of drugs, cost of surgery and cost of management;

"**healthcare facility**" includes a hospital, a nursing home, laboratory, maternity, dental clinic, polyclinic, clinic, pharmacy and any other facility that the Council may determine;

"**indigent**" has the same meaning it has in the Act;

"**means test**" has the same meaning it has in the Act;

"**monitoring performance**" has the same meaning as performance monitoring in the Act;

"**mutual health insurance scheme**" has the same meaning it has in the Act;

"**peer review**" means the process by which the treatment of a patient or the performance of a healthcare professional is reviewed by a professional colleague either within the professional organisation or healthcare facility;

"**quality assurance**" has the same meaning it has in the Act;

"**resident**" means a person who lives in this country for six months or more in any period of twelve months.

(2) The abbreviations found in these Regulations have the interpretation as set out in Schedule III

Regulation 64—Transitional provision

Notwithstanding any provision of these Regulations to the contrary, the Council is empowered to take such administrative measures as it considers necessary to enable schemes to obtain healthcare services from healthcare facilities that are not yet accredited by the Council for such period as the Council finds necessary.

Regulation 65—Revocation

The Hospital Fees Regulations 1985 (L.I. 1313) are hereby revoked.

SCHEDULES

SCHEDULE I

FORM 1

(Regulation 2)

**NHIS
FORMS 1**

PART I

APPLICATION FOR REGISTRATION AS A HEALTH INSURANCE SCHEME

(regulation 2)

PART I—PARTICULARS OF APPLICANT

1. Name of applicant.....
.....
2. Head office, postal address, telephone, e-mail, fax.....
.....
.....
.....
3. Type of health insurance scheme to be registered (private/commercial, private mutual, district mutual health insurance scheme)
4. Name, address and occupation of directors.....
.....
.....
.....

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.....
5. Principal
officer/manager.....
.....
6. Name, address and qualifications of chief accounting
officer.....

-
.....
7. Name, address of
auditors.....

-
.....
-
.....

Note:

- * Attach annexures wherever necessary.
- * Do not leave any question blank or unanswered: where necessary, answer "Not applicable" or "Not known".
- * Upon completion, the original of this Form and supporting annexures should be submitted to:

The National Health Insurance Council

P. O. Box

Accra.

8. Total number of all classes of
employees.....
9. Name and address of
bankers.....

-
.....
-
.....

10. Number of members of the scheme and estimated dependants of members as at the date of the application

.....

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11. Provide details of applicant's past and present membership of or affiliation to any association concerned with health insurance schemes in Ghana or elsewhere, including details of any refusal, termination or lapsing of such membership or affiliation and the reason for it.

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12. Is any director of the applicant a director of another scheme that carries on business in Ghana?
YES/NO. If yes, provide details.....

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.....

.....

13. The applicant or any director of the applicant ever, under the laws of this country or any other country has—

(a) been adjudged or otherwise declared insolvent or bankrupt and has not been rehabilitated or discharged? YES/NO.

(b) made an assignment to, or arrangement or composition with, his or her creditor which has not been rescinded or set aside? YES/NO.

(c) been convicted of theft, fraud, forgery, uttering a forged document or perjury or any other offence, that is similar to any of these offences? YES/NO.

(d) been convicted of any offence and sentenced to a term of imprisonment exceeding six months, without the option of a fine, and has not received a free pardon? YES/NO.

If the answer to any of these questions is yes, provide details.

Declaration

We, the undersigned principal officer and board of directors of the applicant, do hereby declare that—

- (a) the information given in response to and in support of the questions and matters in this Part of this application is true and correct to the best of our knowledge and belief;
- (b) this application is made in good faith with the purpose and intent that the affairs and business of the applicant will at all times be honestly conducted in accordance with good and sound principles and in full compliance with all applicable laws.

Dated

this.....
.....

Chairperson of the Board (print name).....

Signature

Principal Officer/Manager (print name).....

Signature

Director (print name).....

Signature

Director (print name).....

Signature

Director (print name).....

Signature

Director (print name).....

Signature

PART II: PARTICULARS OF PRINCIPAL OFFICER OR MANAGER

14. Name and address of principal officer or manager (address of head office in the case of a corporate manager):

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15. In the case of a corporate independent manager, name and address of the chief executive

.....
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16. Professional and academic qualifications and employment history (for the past 5 years, listing, in reverse chronological order, the name and address of the employer, the nature or type of business, job title and duties, the date employed and reasons for leaving) of the principal officer and manager or, in the case of a corporate independent manager, the chief executive of the manager.

17. Does the principal officer or manager act in the capacity of a principal officer or independent manager, or member of the governing board, of any other schemes? YES/NO. If yes, provide details.

18. Has the principal officer or manager or, in the case of a corporate independent manager, any director of the manager ever, under the law of this country or any other country

- (a) been adjudged or otherwise declared insolvent or bankrupt and has not been rehabilitated or discharged? YES/NO
- (b) made an assignment to, or arrangement or composition with, his or her creditors which has not been rescinded or set aside? YES/NO
- (c) been convicted of theft, fraud, forgery, uttering a forged document or perjury or any other offence, that is similar to any of these offences? YES/NO
- (d) been convicted of any offence and sentenced to a term of imprisonment exceeding six months, without the option of a fine, and has not received a free pardon? YES/NO

If the answer to any of these questions is yes, provided details.

Declaration by principal officer/manager or chief executive of independent manager I, the undersigned, do hereby declare that all information given in response to and in support of the questions and matters in Part II of this application is true and correct to the best of my knowledge and belief.

Dated

this.....
.....

.....
.....

Name and signature of principal officer/manager or name and signature of chief executive of the independent manager.

Annexures to this application Form provide as applicable to type of scheme

1. List of branch offices, address, telephone, e-mail, fax.
2. Certified copy of certificate of incorporation under the Companies Code 1963 (Act 179).
3. Constitution, bye-laws or rules in the case of district mutual or private mutual scheme.

4. Financial statement and cash flow for the two years preceding the date of the application for an existing scheme.
5. In the case of a private/commercial health insurance company a feasibility study and projection for the first two years of operation containing the following data:
 - (a) cash-flow analysis;
 - (b) gross premium income and expenditure projections;
 - (c) assessment of the prospects and profit potential for the next five years.
6. Evidence of the ability to pay security deposit required where applicable.

NHIS

FORM 2

ACCREDITATION OF HEALTH CARE FACILITY APPLICATION FORM

(Regulation 28(1))

Note: If any space is insufficient for the information required, please provide additional information on a separate sheet and where documents are required, please attach certified copies.

1. Name of healthcare facility.....

.....
.....

2. Location (Street name, House No).....

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

3. Postal address and Telephone/Fax/Email:.....

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

4. Town..... District Region

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

5. Name of Chief Executive/Administrator/Proprietor:.....

.....
.....

6. Facilities:

1. Health care available.....
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2. Laboratory.....
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3. Surgery.....
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4. Maternity.....
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5.
Dental.....
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6.
Physiotherapy.....
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7. Health personnel

1. Number of medical
practitioners:.....
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.....
.....

2. Number of
Nurses:.....
.....

.....
.....

3. Number of
Dentists:.....
.....

.....
.....

4.
Others.....
.....

5. Evidence of qualifications of healthcare
personnel.....

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Declaration
I

..... Chief Executive/Administrator/Proprietor of
..... hereby declare that to the
best of my knowledge and belief, the information given on this application form is correct.

Date:..... Signature:.....

NHIS
FORM 3

REPUBLIC OF GHANA
(Ministry of Health)
CERTIFICATE OF ACCREDITATION
(Regulation 30(1))

Certificate

No.....
.....

This is to certify that the health care facility known
as:.....

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

situated
at.....
.....

has been granted accreditation in terms of regulation 28 of the National Health Insurance
Regulations 2004 (L.I.) for a period of year with effect from
..... to

.....

Chairperson
National Health Insurance Council

Executive Secretary
National Health Insurance Council

Seal:

This certificate remains the property of the National Health Insurance Council and must be surrendered on demand.

DISTRICT MUTUAL HEALTH INSURANCE SCHEME
..... **SUB-METRO/DISTRICT**

NHIS
FORM 4

IN-PATIENT TREATMENT COSTING SHEET

(Regulation 62)

..... **HEALTH FACILITY**

Patient Name..... Admitted..... Discharged
.....

ID No Insurance
No.....

Patient Number..... HFAC Patient
Type.....

Hospital Ward..... RFFC..... Corp Name..... Debtor's
No.....

| DATE | DG NO. | CODE | DESCRIPTION | QTY. | UNIT PRICE | AMOUNT | PROVIDER'S SIGNATURE |
|------|-----------|------|-------------|------|---------------|--------|-------------------------|
| | | | | | | | |
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| | | | | | | | |
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| | | | | | | | |
| | | | | | | | |

PATIENT TYPE: 1-PAYING 2-FREE 3-HEALTH INSURANCE

DISTRICT MUTUAL HEALTH INSURANCE SCHEME
..... **SUB-METRO/DISTRICT**

NHIS
FORM 5

HEALTH FACILITY ATTENDANCE CARD

(Regulation 62)

Sick
Picture
Here

Please check code for each episode.

| Episodes | | Codes | | | | | | |
|----------|--|----------|--|----------|--|--------|--|--|
| FD Code | | CCY Code | | MED Code | | CONTRA | | |
| 1. | | | | | | | | |
| 2. | | | | | | | | |
| 3. | | | | | | | | |
| 4. | | | | | | | | |
| 5. | | | | | | | | |
| 6. | | | | | | | | |
| 7. | | | | | | | | |
| 8. | | | | | | | | |
| 9. | | | | | | | | |
| 10. | | | | | | | | |

| DT | HFAC | HFC | Signature (Scheme) | Signature (F. Desk) | Signature (Diagnostic) | Signature (Pharmacy) | Signature (Med. Doctor) |
|----|------|-----|-----------------------|------------------------|---------------------------|-------------------------|----------------------------|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

DISTRICT MUTUAL HEALTH INSURANCE SCHEME

.....SUB-METRO/DISTRICT

**NHIS
FORM 6**

DIAGNOSTIC CARD

(Regulation 62)

HEALTH FACILITY **Date**

Client's Surname..... First Name
.....

Unique No ID No..... H/No.
.....

CONTRA..... HFC
HFAC.....

D Code(s)..... OPD
No.....

Prescriber's
Name.....

....

Prescriber's ID No.
Tel.....

| Date | DF Code | Diagnostic Test | Test Code | Amount | Signature | Staff Code |
|--------------|---------|-----------------|-----------|--------|-----------|------------|
| | | | | | | |
| Total Amount | | | | | | |

(1)
Name (Professional in-charge) Code DFC

(2)
Name (Professional in-charge) Code DFC

(3)
Name (Professional in-charge) Code DFC

DISTRICT MUTUAL HEALTH INSURANCE SCHEME

.....SUB-METRO/DISTRICT

NHIS
FORM 7

PRESCRIPTION CARD

(Regulation 62)

HEALTH FACILITY
Date.....

Client's Surname First Name
.....

Unique No. ID No.
H/No.....

CONTRA..... HFC
HFAC.....

D Code(s)..... OPD
No.....

Prescriber's Name
.....

Prescriber's ID No.
Tel.....

| Date | Drug | Description | Qty. | Amount | Supplier Code | Supplier |
|------|------|-------------|------|--------|---------------|----------|
|------|------|-------------|------|--------|---------------|----------|

| | | | | | | |
|--------------|------|--|--|--|--|-----------|
| | Code | | | | | Signature |
| Total Amount | | | | | | |

(1)
Stamp (Health Facility) HCC SCC

(2)
Stamp (Health Facility) HCC SCC

(3)
Stamp (Health Facility) HCC SCC

FOR OFFICE USE ONLY

| DATE | CLAIM ACTIVITY | CODE | OFFICER IN CHARGE | SIGNATURE |
|------|--------------------------------|------|-------------------|-----------|
| | RECEIVED | | | |
| | VALIDATION | | | |
| | DATA ENTRY | | | |
| | DATA VALIDATION | | | |
| | CONTROL PROCESSING | | | |
| | ACCEPTANCE | | | |
| | REJECTION | | | |
| | REVIEW | | | |
| | REVIEW ACCEPTANCE | | | |
| | REVIEW REJECTION | | | |
| | PAYMENT | | | |
| | REJECTED CLAIM SENT BACK TO HF | | | |

DISTRICT MUTUAL HEALTH INSURANCE SCHEME

..... SUB-METRO/DISTRICT

**NHIS
FORM 8**

CLAIMS FORM

(Regulation 62) Date

Client's Surname First Name.....

Unique No. ID No..... H/No.

CONTRA REF..... RFT

HFC.....

GTS..... HFAC..... Review Status.....
.....

Status No. D No
PCD.....

Doctor's Name.....
.....

Doctor's ID
No.....

Diagnosis D.
Code.....

(Please complete if Client is admitted)

Admission (Date)..... Authorized by (Name and
Code).....

Discharge(Date)..... Authorized by (Name and
Code).....

Ward No Bed
No.....

(Please complete the relevant cells)

| Activity | NON-DRUGS | | | | DRUGS | | | |
|--------------------|-----------|--------|-----------|------|-------|--------|-----------|--|
| HD Code | HW Code | Amount | Signature | Code | Qty. | Amount | Signature | |
| Consultation | | | | | | | | |
| D. Test | | | | | | | | |
| D. Test | | | | | | | | |
| D. Test | | | | | | | | |
| D. Test | | | | | | | | |
| D. Test | | | | | | | | |
| Blood Bank | | | | | | | | |
| Dressing/Injection | | | | | | | | |
| Delivery | | | | | | | | |
| Admission | | | | | | | | |
| Theatre | | | | | | | | |
| Feeding | | | | | | | | |
| Others | | | | | | | | |
| SUB-TOTAL | | | | | | | | |
| GRAND TOTAL | | | | | | | | |

.....
Signature (Doctor)

.....
Date

.....
Signature (Claims Dispatch Officer)

.....
Date

DISTRICT MUTUAL HEALTH INSURANCE SCHEME

..... SUB-METRO/DISTRICT
DISTRICT MUTUAL HEALTH

**NHIS
FORM 9**

MEMBERSHIP/HOUSEHOLD REGISTRATION
COMPLETE ALL DETAILS REQUESTED (PEASE PRINT CLEARLY)

SECTION 1 PERSONAL DETAILS HOUSEHOLD HEAD

Family Name First Names (in full).....

Sex M ☐ F ☐ Date of Birth Age

Unique No..... H/No.....

WPC.....

ID No. Marital Status.....

Nationality..... N. Code.....

Educational Attainment..... Habitation Status.....

Parent Status Amount Payable.....

Occupation..... Occupation Code.....

SECTION 2 CONTACT DETAILS HOUSEHOLD HEAD

Residential Address Address Code.....

Tel No Cell Phone No.....

SECTION 3 EMPLOYMENT DETAILS HOUSEHOLD HEAD

Name of Company/Institution.....

Sector ID Company Unique ID.....

Location Address Address Code.....

WPS Activity Code Size Code.....

Tel. No Fax No

E-Mail

| | |
|------------------|-------------------|
| SECTION 4 | DEDUCTIONS |
|------------------|-------------------|

2.5% Deduction Net Monthly
Income.....
SSNIT Deductions

| | |
|------------------|----------------------------------------|
| SECTION 5 | PERSONAL DETAILS HOUSEHOLD HEAD |
|------------------|----------------------------------------|

Family Name First Names (in
full).....

Sex M ☐ F ☐ Date of Birth
Age.....

Unique No H/No
WPC.....

ID No. Marital
Status.....

Nationality..... N.
Code.....

Educational Attainment..... Habitation
Status.....

Parent Status..... Amount
Payable.....

Occupation..... Occupation
Code.....

| | |
|------------------|--------------------------------|
| SECTION 6 | CONTRACT DETAILS SPOUSE |
|------------------|--------------------------------|

Residential Address Address
Code.....

Tel. No Cell Phone
No.....

| | |
|------------------|----------------------------------|
| SECTION 7 | EMPLOYMENT DETAILS SPOUSE |
|------------------|----------------------------------|

Name of
Company/Institution.....

Sector ID..... Company Unique ID
H/No.....

Location Address..... Address
Code.....

WPS..... Activity Code..... Size
Code.....

Tel. No Fax
No.....

E-Mail

| | |
|------------------|-------------------|
| SECTION 8 | DEDUCTIONS |
|------------------|-------------------|

2.5% Deduction..... Net Monthly Income.....
.....
SSNIT Deductions

| SECTION 9 PERSONAL DETAILS (CHILDREN/DEPENDANTS) | | | | | | | | | | |
|--------------------------------------------------|---------------|-----|-----|------|------|------------|---------|----------|-----------|----------------------|
| Name | Date of Birth | Age | Sex | Occ. | Nat. | WPC Status | Marital | HHS Code | Relations | Signature/Thumbprint |
| | | | | | | | | | | |

I/We hereby declare that the content of the form have been examined and certified as correct.

I/We also accept to joinHealth Insurance scheme with my/our family and pledge to adhere to the tenets of the NHIS Act 650, the Regulations made under the Act and the Scheme's constitution.

.....
Signature/Thumbprint
(Head of Household)
(Spouse)

.....
Signature/Thumbprint

DISTRICT MUTUAL HEALTH INSURANCE SCHEME

**NHIS
FORM 10**

COMPLAINT FORM

(Regulation 43 (3))

1. Name and address of complainant.....

.....
.....

2. Name of Scheme.....

.....

3. District.....

.....

4. Person/body against whom the complaint is made.....

.....

.....

5. Record of earlier submission of the complaint to the scheme.....

.....

.....

.....
.....
6. The nature of injustice, harm or damage suffered arising from the action, inaction or omission of the person against whom the complaint is made.....
.....
.....

7. The relief sought by the complainant.....
.....

8. Any other matter relevant to the complaint.....
.....
.....

Date:
Signature:.....

SCHEDULE II

PART I

(Regulation 19(1))

MINIMUM HEALTHCARE BENEFITS

The healthcare services specified in this Part are the minimum healthcare benefits under the national health insurance scheme and shall be paid for by the schemes.

1. Out-patient Services

- (1) Consultations including reviews: These include both general and specialist consultations.
- (2) Requested Investigations including laboratory investigations, x-rays and ultrasound scanning for general and specialist out-patient services.
- (3) Medication, namely, prescription drugs on National Health Insurance Scheme Drugs List, traditional medicines approved by the Food and Drugs Board and prescribed by accredited medical and traditional medicine practitioners.
- (4) HIV/AIDS symptomatic treatment for opportunistic infection.
- (5) Out-patient/Day Surgical Operations including hernia repairs, incision and drainage, haemorrhoidectomy.
- (6) Out-patient Physiotherapy.

2. In Patient services

- (1) General and Specialist in-patient care.

- (2) Requested Investigations including laboratory investigations, x-rays and ultrasound scanning for in-patient care.
- (3) Medication, namely, prescription drugs on National Health Insurance Scheme List, traditional medicines approved by the Food and Drugs Board and prescribed by accredited medical and traditional medicine practitioners, blood and blood products.
- (4) Cervical and Breast Cancer Treatment
- (5) Surgical Operations.
- (6) In-Patient Physiotherapy.
- (7) Accommodation in general ward.
- (8) Feeding (where available)

3. Oral Health services including

- (a) Pain Relief which includes incision and drainage, tooth extraction and temporary relief;
- (b) Dental Restoration which includes Simple Amalgam Fillings and Temporary Dressing.

4. Eye Care services including

- (a) Refraction;
- (b) Visual Fields;
- (c) A- Scan;
- (d) Keratometry;
- (e) Cataract Removal;
- (f) Eye Lid Surgery;

5. Maternity care including

- (a) Antenatal Care;
- (b) Deliveries, namely, normal and assisted;
- (c) Caesarian Section;
- (d) Postnatal care.

6. Emergencies

All emergencies shall be covered. These refer to crisis health situation that demand urgent intervention and include,

- (a) Medical emergencies;
- (b) Surgical emergencies including brain surgery due to accidents;
- (c) Paediatric emergencies;
- (d) Obstetric and Gynaecological emergencies including Caesarian Sections;
- (e) Road Traffic Accidents;
- (f) Industrial and workplace Accidents;
- (g) Dialysis for acute renal failure.

7. Accessing Services Under the Health Insurance Scheme

- (1) The first point of attendance, except in cases of emergency, shall be a primary healthcare facility, which includes Community-based health Planning and Services (CHIPS), Health Centres, District Hospitals, Polyclinics or Sub-metro Hospitals, Quasi Public Hospitals,

Private Hospitals, Clinics and Maternity Homes.

- (2) In localities where the only health facility is a Regional Hospital, the General patient department shall be considered a primary healthcare facility.
- (3) All health care services provided in these facilities shall be paid for by the District Mutual health Insurance Schemes (DMHIS).
- (4) In cases where the services are not available, all referred cases other than those in the Exclusion List shall be paid for by DMHIS.
- (5) Emergencies shall be attended to at any health facility.

SCHEDULE II—PART 2

(Regulation 20)

EXCLUSION LIST

1. The healthcare services specified in this Part of this Schedule are not covered under the minimum benefits available under the National Health Insurance Scheme.
2. Health insurance schemes may decide to offer any of these as additional benefits to their members.

Excluded are the healthcare services that fall under any of these groups;

- (a) Rehabilitation other than physiotherapy;
- (b) Appliances and prostheses including optical aid, hearing aids, orthopedic aids, dentures;
- (c) Cosmetic surgeries and aesthetic treatments;
- (d) HIV retroviral drugs
- (e) Assisted Reproduction eg. Artificial insemination and gynaecological hormone replacement therapy;
- (f) Echocardiography;
- (g) Photography
- (h) Angiography;
- (i) Orthoptics;
- (j) Dialysis for chronic renal failure;
- (k) Heart and brain surgery other than those resulting from accidents;
- (l) Cancer treatment other than cervical and breast cancer;
- (m) Organ transplantation;
- (n) All drugs that are not listed on the NHIS Drug List;
- (o) Diagnosis and treatment abroad;
- (p) Medical examinations for purposes of visa applications, educational, institutional, driving licence;
- (q) VIP ward (Accommodation);
- (r) Mortuary Services.

PART 3

(Regulation 19(4))

FREE PUBLIC HEALTH SERVICES

The following healthcare services are free:

- (a) Immunization;
- (b) Family planning;
- (c) In-patient and Out-patient treatment of mental illnesses;
- (d) Treatment of Tuberculosis, Onchocerciasis, Buruli Ulcer, Trachoma;
and
- (e) Confirmatory HIV test on AIDS Patients.

SCHEDULE III

(Regulation 63 (2))

NATIONAL HEALTH INSURANCE SCHEME (NHIS) OPERATIONAL ABBREVIATION INTERPRETATIONS

| | |
|--------------|-------------------------------------------|
| 1. GTS | — Gate Keeper Status |
| 2. RFF | — Referral Facility (from) |
| 3. RFT | — Referral Facility (to) |
| 4. RS | — Review Status |
| 5. FD Code | — Front Desk Code |
| 6. CCY | — Consultancy Code |
| 7. PH Code | — Pharmacy Code |
| 8. Contra DF | — Diagnostic Facility Contra |
| 9. DT | — Date |
| 10. HFAC | — Health Facility Attendance Control Code |
| 11. HFC | — Health Facility Code |
| 12. PSC | — Patient Status Code |
| 13. DG | — Diagnosis |
| 14. OCC Code | — Occupation Code |
| 15. WPC | — Work Place Code |
| 16. WPS | — Work Place Status |
| 17. DFC | — Diagnostic Facility Code |
| 18. RC | — Results Code |
| 19. T | — Test |
| 20. R | — Results |
| 21. PC | — Patient Code |

| | |
|------------|--------------------------------|
| 22. CP | — Co-payment |
| 23. ID | — Identification |
| 24. HI | — Health Insurance |
| 25. HD | — Health Delivery |
| 26. HW | — Health Worker |
| 27. PSN | — Patient H.I. Scheme Number |
| 28. SC | — Supplier Control Code |
| 29. HFCC | — Health Facility Control Code |
| 30. HF | — Health Facility |
| 31. RC | — Relations Code |
| 32. HHS | — Household Status |
| 33. HN | — Household Number |
| 34. H | — House Number |
| 35. T | — Town/Village/Community |
| 36. S | — Street/Road/Path |
| 37. AG | — Age |
| 38. BAL | — Balance |
| 39. FA | — Facility Attendance |
| 40. DST | — Disease Status |
| 41. DS | — Disease Code. |
| 42. D-TEST | — Diagnostic Tests |

DR. KWEKU AFRIYIE

Minister Responsible for Health

Date of Gazette Notification: 24th September, 2004.

ⁱ(3)