# Pre-authorization request form

| | |
|---|---|
| Hospital name | Contact number & address |
| Physician name | Contact number |

## A. Administrative

| | | |
|---|---|---|
| Patient name | Date of birth | Patient mobile# |
| Insurance card # | Group/ company name | |
| Date of admission | Date of discharge | |

If emergency admission, details about cause, date, place of accident

## B. Medical Section

| | |
|---|---|
| Symptoms presented | Date on which the patient first presented to any doctor for this condition |
| | Date the patient first became aware of any signs or symptoms for this condition |

Details of medical condition

Full details of proposed treatment / surgery

## C. Total cost of treatment (itemized breakdown of charges)

| Charges | Cost |
|---|---|
| | |
| | |
| | |

Length of stay

## D. Other insurer's details (please tick appropriate box)

| | |
|---|---|
| Is the disease/injury work related? ☐ Yes ☐ No | Is the disease/injury accident related? ☐ Yes ☐ No |

Is it covered under another insurance policy? If 'Yes' please give the name of the insurance company involved

## E. Approval request for: (please tick appropriate box)

☐ Inpatient ☐ Daycare ☐ Out-patient surgery ☐ Physiotherapy ☐ MRI/CT scan ☐ Dental ☐ Maternity

Other, please specify

## Medical practitioner declaration

I declare that I am the patient's medical practitioner, and that the particulars given are, to the best of my knowledge, true and correct.

Signature: Stamp:

Date:

## F. Seib Insurance response

| | |
|---|---|
| Maximum cost approved: | Prior approval #: |
| Maximum stay approved: | Date: |

Authorized signature:

N.B: If the approved cost of treatment or maximum stay is to be exceeded, further approval must be sought before discharge. All unapproved charges are the responsibility of the patient and must be recovered by the hospital/clinic from the patient prior to discharge.

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