

Pre-authorisation Form

Please read the guidelines overleaf, ensure that all relevant information is completed in **BLOCK CAPITALS** and that the relevant boxes are ticked.

1 Insured section - to be fully completed by the insured member/patient

Name of patient

Date of birth / /

Policy number

Telephone COUNTRY CODE AREA CODE

Fax COUNTRY CODE AREA CODE

Email

2 Provider section - to be fully completed by the medical provider

Hospital/facility name and address

Email

Telephone COUNTRY CODE AREA CODE

Fax COUNTRY CODE AREA CODE

Name of the attending/admitting doctor

Admission type: In-patient Out-patient Dental

Diagnosis (ICD-10) or any other code if available, otherwise a full description

Planned procedure with medical justification

For in-patient treatment

Planned admission date / /

Estimated cost (incl. currency)

Estimated length of stay

For maternity cases only

Date pregnancy confirmed by doctor / /

Expected or actual date of delivery / /

Is the birth of a single baby expected? Yes No

If No, is the pregnancy a result of medically assisted reproduction other than artificial insemination? Yes No

Please sign, date and authenticate with an official stamp.

Doctor's signature _____

Date / /

Official stamp of medical provider

