Pre-authorization request form

Physician name

Hospital name

Contact number

Contact number & address

1. **Administrative**

Date of birth

Group/ company name

Insurance card #

Date of admission

Patient name

Date of discharge

Patient mobile#

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

1. **Medical Section**

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

Full details of proposed treatment / surgery

Details of medical condition

Symptoms presented

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

Charges Cost

Length of stay

1. **Other insurer’s details (please tick appropriate box)**

Is the disease/injury accident related?  Yes  No

Is the disease/injury work related?  Yes  No

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

1. **Approval request for: (please tick appropriate box)**

Other, please specify

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

**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**

Authorized signature:

Date:

Prior approval #:

Maximum stay approved:

Maximum cost approved:

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.