

### Pre-authorization Request Form

Hospital name:	<input type="text"/>	Contact no:	<input type="text"/>	Date Received:	<input type="text"/>
Physician name:	<input type="text"/>	Contact no:	<input type="text"/>	No. of pages:	<input type="text"/>

#### A. Administrative

Membership No.	<input type="text"/>	Group/ Company Name	<input type="text"/>
Patient Date of Birth	<input type="text"/>	Gender	<input type="text"/>
Policy/Group no.	<input type="text"/>	Plan	<input type="text"/>
Date of Admission	<input type="text"/>	Date of Discharge	<input type="text"/>
If emergency admission, details about Cause, Date, Place of accident		<input type="text"/>	

#### B. Medical Section

Symptoms presented	<input type="text"/>	Date the patient first became aware of any signs or symptoms for this condition	<input type="text"/>	Date on which the patient first presented to any doctor for this condition	<input type="text"/>
Details of medical condition	<input type="text"/>				
Full details of proposed treatment/surgery	<input type="text"/>				

#### C. Total Cost of Treatment (itemized breakdown of charges)

Charges	Cost
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
Length of stay	<input type="text"/>

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

Is the treatment work related?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the treatment accident related?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is it covered under another insurance policy? If 'yes' please give the name of the Insurance Company involved			
<input type="text"/>			

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

<input type="checkbox"/> Inpatient	<input type="checkbox"/> Daycare	<input type="checkbox"/> Out-Patient Surgery	<input type="checkbox"/> Physiotherapy	<input type="checkbox"/> MRI/CT Scan	<input type="checkbox"/> Dental	<input type="checkbox"/> Maternity
Other please specify						
<input type="text"/>						

#### 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 Response

Maximum Cost approved	<input type="text"/>	Prior approval no:	<input type="text"/>
Maximum Stay approved	<input type="text"/>	Date:	<input type="text"/>

#### Authorized Signature

N.B: If the approved cost of treatment or maximum stay are 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 patients prior to discharge.