

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.