سّيب Seib تأمين وإعادة تأمين INSURANCE & REINSURANCE

Pre-authorization Request Form

Hospital name:		**Contact no:**		**Date Received:**	
Physician name:		**Contact no:**		**No. of pages:**	

A. Administrative

Membership No.				**Group/ Company Name**	
Patient Date of Birth dd/mm/yyyy		**Gender**	Select Gender	**Patient Name**	
Policy/Group no.		**Plan**		**Patient Phone**	
Date of Admission		**Date of Discharge**			
If emergency admission, details about Cause, Date, Place of accident					

B. Medical Section

Symptoms presented		Date the patient first became aware of any signs or symptoms for this condition	Date on which the patient first presented to any doctor 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 treatment work related?	☐ Yes	☐ No	**Is the treatment 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 practioner, and that the particulars given are to the best of my knowledge true and correct.

Signature: Stamp:

Date:

F. Seib Response

Maximum Cost approved		**Prior approval no:**	
Maximum Stay approved		**Date:**	

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 reponsibility of the patient and must be recovered by the hospital/clinic from the patients prior to discharge.