LIBERTY

FOR OFFICIAL USE ONLY

Member/ policy number

HEALTH COVER

Zambia Hospital Pre-Authorisation Form

Important: please read the following before completing this application form

- Please write clearly using capital and block letters.
- It is compulsory to complete all the fields in this form.

1. PERSONAL DETAILS | PRINCIPAL MEMBER OR POLICYHOLDER

Please complete in block capitals

Last name

First names

Title

Medical Insurer

Membership or policy number

ID/ Passport number

2. GENERAL PATIENT INFORMATION

Please complete in block capitals

Patient's last name

Patient's first name(s)

Patient dependant code

Gender M F

Date of birth Y Y Y Y M M D D

Home telephone (please include country and area code) +

Mobile (please include country and area code) +

E-mail

Physical address

Postal code

Postal address (if different to physical address)

Postal code

3. DOCTOR AND PROVIDER DETAILS

Please complete in block capitals

Hospital name

Speciality

Treating doctor's last name

Treating doctor's first name(s)

Speciality

Practice/Registration No.

Work telephone (please include country and area code) +

Fax (please include country and area code) +

Mobile (please include country and area code) +

E-mail

Physical address

Postal code

Postal address (if different to physical address)

Postal code

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

ADMISSION DETAILS

Please complete in block capitals

Date of admission Y Y Y Y M M D D Time of admission : AM PM

Ward Type

General Surgical Maternity Paediatric Isolation Day ward Psych ICU

Date of discharge Y Y Y Y M M D D

Clinical reason for admission

Initial diagnosis

ICD-10 code

Discharge diagnosis

ICD-10 code

Description of procedure/operation

Tariff code

CPT code Emergency admission Y N

TREATMENT PLAN (CLINICAL SIGNS, SYMPTOMS AND TREATMENT IN HOSPITAL, IE: MEDICATION NAME AND DOSAGE)

Scan request

Name of radiology practice

Referring doctor's name

Referring doctor's speciality

Scan type requested

Please provide motivation/reason

MRI scan

Tarrif/CPT Code

Description

CT scan

Tarrif/CPT Code

Description

ACKNOWLEDGEMENT BY EXAMINING DOCTOR

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

Having conducted a personal medical examination, I certify that the particulars are, to the best of my knowledge and belief, true and accurate . I acknowledge that the Insurer will rely on such particulars when making any recommendations regarding the payment of treatment and services.

Doctor's last name

Doctor's first name(s)

Doctor's signature

Date Y Y Y Y M M D D

PATIENT'S DECLARATION

I hereby declare that the information in this form is true and correct. I am aware that the Insurer may request medical information from any medical facility, laboratory, clinic, hospital, doctor or specialist that it requires.

In order to fully assess this application for benefits, I hereby give my consent for the Insurer to obtain this information. I understand that this application is subject to the Liberty Health Cover Policy Conditions and benefits.

Patient's signature

Date Y Y Y Y M M D D