

## Pre-authorisation Approval Request Form

Name of hospital

Tel  Fax

Name of company/client

Employee name  Gender  M  F

Staff No. (if available)

ID number  Policy/Membership No.

Tel (Member's)

Patient's name  Date of Birth  DD -  MM -  YYYY

Provisional/Final diagnosis: .....

When was the condition first diagnosed?  DD -  MM -  YYYY  When was the condition last treated?  DD -  MM -  YYYY

Cause of illness/es: .....  
(or any known underlying condition)

Is the condition congenital/recurring: .....

Surgical  Y  N  Is this the first Caesarean  Y  N

Has an HIV test been done?  Y  N  If yes, what are the results? .....

Approval request for (tick as appropriate):

Emergency in-patient  CT Scan  Non-emergency  MRI  
 Non-emergency out-patient surgery  Physiotherapy  Dialysis  Angiogram

Others (please specify): .....

Brief history and findings: .....

Initial plan of management: .....

Estimated hospitalisation duration: ..... Estimated cost of Treatment: .....

Doctor's name: ..... Tel: .....

### PROVIDER'S DECLARATION

I hereby confirm that the information provided above is correct and true to the best of my knowledge.

Doctor's stamp

Signed \_\_\_\_\_ Date  DD  MM  CC  YY

### PATIENT/PATIENT'S GAURDIAN DECLARATION

I ..... do hereby authorise any doctor, hospital, clinic or medical provider, any other company, institution or person who has record or information about me and/or my family members to provide my Insurer with complete information including copies of their records with reference to my sickness or accident, any treatment, examination, advice or hospitalisation. **I have also been advised by ..... and have understood the various exclusions.** Any photocopy of this authorisation shall be taken as the original copy. *I WILL SUBMIT MY NHIF CARD (If NHIF Contributor) within 24 hours from time of the admission.*

Patient/Parent/Guardian's name: \_\_\_\_\_

Patient/Parent/Guardian's signature: \_\_\_\_\_

Cell phone no. \_\_\_\_\_

Date  DD  MM  CC  YY