PRE-AUTHORISATION REQUISITION

Fax to +255 22 2602385

This form is valid only for members and their registered dependants whose names appear on the membership cards or schedules and updated forms from Strategis Insurance and those specifically.
I give my consent to Strategis Insurance (Tanzania) Limited to review my medical records and communicate with my medical practitioner(s) on all matters relating to this admission.

Members signature Date:

Strategis Insurance

After office hours and on holidays. ONLY IN EMERGENCY, the healthcare provider may provide services and seek authorisation within 24 hours of the beginning of the next working day.

Hospital name:	Fax No.:
Employer's name:	Plan:
Patients full name (as per the card):	
Membership number	Age of patient:
Please provide details of symptoms requiring treatment:	
On what date did the patient first present with these symptoms? / /	
Please provide diagnosis:	
Please provide details of the procedure or treatment required:	
In your opinion, would you consider the medical condition to be (please circle): 1. Acute 2. Chronic 3. Acute episode of a chronic condition	
What is the patient's prognosis (please circle): 1. Excellent 2. Good 3. Poor	
Date of admission:	Expected length of stay:
Estimated cost (in Tsh):	

I declare that to the best of my knowledge and belief the statements made on this claim are full, true and complete.

Doctors name: ..... Signature: ..... Date / /

For Strategis Insurance (Tanzania) Limited use only

Authorisation number: _____

Time period: _____

Financial Limit of authorisation required: Tsh _____

Strategis Insurance hereby guarantees cost of necessary medical expenses on this subject to a maximum of the financial limit mentioned above. When the case has reached 90% of the above limit and if ti si felt that the treatment expenses would cross the authorised financial limit given above, please seek further approval quoting this authorisation number well in time.

Case Manager's Signature Date:

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