

Liberty Health Cover

Hospital and Scan Pre-authorisation Form



LIFE INVESTMENTS INSURANCE **HEALTH** PROPERTIES ADVICE

Important: please read the following before completing this application form

- Please write clearly using capital and block letters.
- Please submit your completed form to our Liberty Health Cover in-country office.
- It is compulsory to complete all the fields in this form.

1. PERSONAL DETAILS | PRINCIPAL MEMBER OR POLICYHOLDER

Please complete in block capitals

First name and last name

Title Membership or policy number

2. GENERAL PATIENT INFORMATION

Please complete in block capitals

Patient's first name and last name

Title Date of birth Y Y Y Y M M D D Gender M F

3. DOCTOR AND PROVIDER DETAILS

Please complete in block capitals

Hospital name

Hospital Practice No.

Treating doctor's first name and last name

Practice/Registration No. Speciality

Work number (include country and area code) +

Mobile (include country and area code) +

E-mail

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

Initial diagnosis & ICD-10 code

Discharge diagnosis & ICD-10 code

Description of procedure/operation

Tariff code CPT code Emergency admission Y N

[illegible]

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.

[illegible][illegible]

Doctor's signature

Date	Y	Y	Y	Y	M	M	D	D
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I am aware that the Insurer may request relevant medical information from any medical facility, laboratory, clinic, hospital, doctor or specialist that it requires to make an appropriate funding decision about my care.

In order for the Insurer to fully assess this application for benefits, I hereby give my consent for them to obtain this information from the relevant healthcare provider. I further understand that this application is subject to the Liberty Health Cover Policy Conditions, available benefits and relevant funding protocols.

Patient's signature	
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Date	Y	Y	Y	Y	M	M	D	D
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