ELECTIVE PRE-AUTHORISATION FORM

Please read the following prior to completing this application form and complete in BLOCK CAPITALS.
Please use a seperate sheet to provide full details if necessary. **UNDER NO CIRCUMSTANCES WILL AN ELECTIVE CLAIM BE APPROVED WITHOUT SUBMISSION OF THIS COMPLETED FORM.**

SECTION 1 - PATIENT'S DETAILS

Needs to be completed by the patient or patient's legal guardian

Surname: Title:

First Name(s):

Date of Birth: DD / MM / YYYY Membership Number:

Group Name (if applicable):

Correspondence Address:

Telephone No: Email:

SECTION 2 - CLAIM DETAILS

Needs to be completed by the patient or patient's legal guardian

1. Is this your first claim for this medical condition? ☐ Yes ☐ No
2. Please detail the symptoms / event for which treatment is being sought:
3. Diagnosis (if known):
4. Date you first noticed symptoms:
5. Are you injured or ill as a result of an accident (e.g. a road accident or an accident at work)? ☐ Yes ☐ No

SECTION 3 - REFERRAL

NEEDS TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTIONER, requesting further treatment or management. This section is only admissable if it is completed by the specialist or referring doctor who is registered in the country where you receive treatment. A copy of the referral letter should be attached to this form.

1. Please give description of symptoms:
2. Diagnosis:
3. Date of onset of symptoms:
4. Has the patient received any treatment / consultation, had any need for treatment or required medication and / or advice for this condition in the past two years? ☐ Yes ☐ No
5. If the answer to Question 4 is yes, please provide details:

SECTION 3 - REFERRAL (CONTINUED)

NEEDS TO BE COMPLETED BY THE REFERRING MEDICAL PRACTIONER. This section is only admissable if it is completed by the specialist or referring doctor who is registered in the country where you receive treatment. A copy of the referral letter should be attached to this form.

6. To whom are you referring this patient? (if applicable):

   Name:

   Specialisation:

7. Date reffered: DD / MM / YYYY

8. What is the likely treatment plan and procedure to be performed:

9. If Medication has been prescribed, please provide details:

10. Hospital admission must be pre-authorised by us.

    Name of hospital:

    Proposed admission date: DD / MM / YYYY

    Address of hospital:

    Expected hospital stay (if known length of stay):

SECTION 4 - DECLARATION

NEEDS TO BE COMPLETED BY THE REFERRING MEDICAL PRACTIONER. This section is only admissable if it is completed by the specialist or referring doctor who is registered in the country where you receive treatment. A copy of the referral letter should be attached to this form.

I hereby certify that I am the patient's doctor

Name:

Correspondence Address:

Telephone No:

Email:

Signature

Practice Stamp

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