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INPATIENT PREAUTHORISATION FORM

PLEASE FILL OUT THIS FORM CLEARLY AND COMPLETELY IN BLOCK LETTERS.

HOSPITAL: ____________________

COMPANY: ____________________

PATIENT'S NAME: ____________________

APA MEDICAL CARD NO.: ____________________

PATIENT'S AGE: ____________ **IS PATIENT AN NHIF MEMBER?** ____________

IS PATIENT INSURED UNDER ANY OTHER MEDICAL SCHEME, WORKMEN'S COMPENSATION, PERSONAL/ACCIDENT? IF SO, GIVE PARTICULARS ____________________

____

DIAGNOSIS: ____________________

WHEN WAS THE CONDITION FIRST DIAGNOSED: ____________________

CAUSE OF ILLNESS (ES): ____________________

____

IS CONDITION LIKELY TO RECUR? ____________________

IS THE CONDITION CONGENITAL? ____________________

HAS THE PATIENT BEEN TESTED FOR HIV? (if so give details): ____________________

____

FOR CAESARIAN SECTION, IS THIS THE <u>FIRST</u> CAESARIAN OPERATION? ____________

IS THIS AN ELECTIVE CAESARIAN OPERATION? ____________________

CLINICAL SUMMARY: ____________________

____

____

DETAILS OF TREATMENT GIVEN & RECOMMENDATIONS: ____________________

____

____

***ESTIMATED COST: Surgeon/Doctor's fees** ____________ **Anaesthetist fee** ____________

Doctors fees: ____________ **Estimated hospital stay (days):** ____________

Doctor's name: ____________ **Doctor's signature:** ____________

Doctor's qualification: ____________ **Telephone no:** ____________

I authorise the Insurance Company to obtain medical information from the doctor I have consulted and shall submit to any medical examination(s) if so required by the Company.

Patient's signature: ____________ **ID No:** ____________

Day time telephone no.: ____________ **Date:** ____________

*** Failure to indicate estimated costs will result in APA fee guidelines automatically being imposed.**