Preauthorisation medical form

Please complete clearly in BLOCK CAPITALS.

For non-emergency preauthorisation requests, please submit this form at least 5 working days before your date of admission to ensure a guarantee of payment can be issued before you are scheduled to receive treatment.

If you do not complete this form clearly and completely there will be a substantial delay to get preauthorisation.

Please return as soon as possible to: aimedicalteamhongkong@aetna.com

Member's information:

Member's name:		Date of birth (dd/mm/yyyy):
Gender: ☐ M ☐ F	Member ID:	Policy no:
Phone/Mobile number:		
Email:		

Provider information:

Name of facility/admitting hospital:	
Address of facility/admitting hospital:	
Name of attending doctor:	Doctor's contact number:
Doctor's clinic name & address:	
Clinic's contact number:	Fax number:
Email:	

Medical condition – to be completed by attending doctor (all fields are mandatory)

Please send any supporting medical documentation (if available) with this completed form (e.g. diagnostic or laboratory test results, imaging, progress notes).

Diagnosis:	ICD 10 Code:
Description of signs/symptoms:	
Underlying cause (if caused by an injury, please elaborate how and when it happened):	
First consultation date (dd/mm/yyyy):	Symptoms/signs from (dd/mm/yyyy):
Please advise if: Chronic? ☐ Yes ☐ No	If yes, when is the onset date of condition (dd/mm/yyyy):
Has this or any similar condition existed previously? ☐ Yes ☐ No	If yes, when is the onset date of condition (dd/mm/yyyy):

Medical condition – to be completed by attending doctor (all fields are mandatory) – continued

Is the medical condition or treatment due to/related to/as a result of any of the following condition(s)?

- ☐ Congenital anomaly/genetic disorder/ physical defects from childbirth
- ☐ Obesity/weight reduction
- ☐ Sleep apnea, sleep-related breathing disorders, snoring and insomnia
- ☐ Mental/psychiatric disorder
- ☐ Cosmetic procedures
- ☐ STD/HIV/AIDS related
- ☐ Alcohol/drug abuse
- ☐ Self-inflicted injuries/attempted suicide
- ☐ Routine check-up/screening

Does the patient have any of the following major comorbidities?

Comorbidities	Yes	No	Date of diagnosis (dd/mm/yyyy):
Cancer			
Stroke, Heart failure, Cardiovascular disease			
Diabetes			
High cholesterol			
Hypertension			
Kidney failure			
Others (please state):			
Previously suffered the same or related diagnosis/illness/symptoms:			

Name of Clinic and Doctor who had treated the patient for the above comorbidity, if available:

Proposed treatment/procedure description:

TOSP code + table (Singapore providers):

Admit as: ☐ Inpatient ☐ Daypatient ☐ Outpatient

Admission date (dd/mm/yyyy):

Estimated length of stay (no. of days):

Cost estimate (to be completed by all relevant parties)

Total Professional Fees breakdown.

TOSP Code and table:

Surgeon's fee: Amount:

Anesthetist fees: Amount:

TOSP Code and table:

Surgeon's fee: Amount:

Anesthetist fees: Amount:

TOSP Code and table:

Surgeon's fee: Amount:

Anesthetist fees: Amount:

Ward round fee per day:

Other Fees (E.g. Secondary treating doctors' fees, surgical implants, medical consumables, and other charges):

Description:	Amount:

Hospital charges:

Class of room: Room rate:

Total bill:

Declaration

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

Attending doctor's name:	
Signature and stamp:	Date (dd/mm/yyyy):

Patient's Release of Medical information

I hereby authorize any doctor of medicine, hospital or other person who has attended or examined me, to give Aetna or the authorised representative, any and all information about sickness or injury, medical history, consultation, prescriptions, or treatment and copies of all hospital and medical records. Please be aware that if you do not provide your authorisation, Aetna might not be able to process your claim / request accordingly. Aetna will only request and process medical information which is adequate, relevant and necessary to process that specific claim / request – this relevant information is required by Aetna Global Benefits (UK) Limited (Singapore Branch) and its affiliates in order to confirm coverage for the medical condition and proposed treatment.

For further information, please see our privacy notice here: www.aetnainternational.com/en/about-us/legal-notices.html.

Patient's name:	
Address of patient:	
Relationship to patient (if you are acting as a designated authority):	
Name of signatory (if you are acting as a designated authority):	
Signature of patient/designated authority:	Date (dd/mm/yyyy):

Financial Sanctions Exclusions

If coverage provided by this policy violates or will violate any United States (US), United Kingdom (U.K.), United Nations (UN), European Union (EU) or other applicable economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments or reimburse for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or entity, or a country under sanction by the US, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information on OFAC, visit **www.treasury.gov/resource-center/sanctions/Pages/default.aspx**.