WorldCare pre-authorisation request form

Administered by: NOW HEALTH INTERNATIONAL

Insured by: RSA

When submitting a pre-authorised claim to **Us**, please return this form with a completed claim form and any supporting documents.

This form should be completed by **Your** treating **Medical Practitioner.**

Please send **Your** completed form to **Us** via **Your** intermediary or direct to Royal & Sun Alliance Insurance Middle East B.S.C. (c), c/o Now Health International Gulf Third Party Administrators LLC, Ground floor, Al Shaiba Building, Dubai Outsource City, PO Box 502163, Dubai, UAE. **You** can also scan and email it to MEAService@now-health.com or fax it to +971 (0) 4450 1416.

Section 1: Medical facility details

Medical facility:		
Email:	Fax:	Telephone number:
Treating **Medical Practitioner**:		
Email:	Fax:	Telephone number:
Patient name:		
Membership number:	Date of birth (dd/mm/yyyy): / /	

Section 2: Approval request (please tick appropriate box)

Elective **Treatment**		
In-Patient ☐	**Day-Patient** ☐	**Out-Patient** surgery ☐
Physiotherapy ☐	PET ☐	Maternity ☐
USA **Treatment** ☐		

Other **Treatment**		
Emergency admission ☐ Please provide full details of nature of illness and **Treatment**:		
Accident ☐ Please provide details of cause, date and place of **Accident**:		
Was a third party involved? if yes, please give details:		
Mortal remains ☐	Psychiatric **Treatment** ☐	AIDS ☐
Other ☐ Please specify:		

Section 3: Treatment details

Full details of condition requiring **Treatment**:

Date the patient first became aware of any signs or symptoms of this condition (dd/mm/yyyy): / /

Date on which the patient first presented to any doctor for this condition (dd/mm/yyyy): / /

Underlying cause (if known):

Provisional diagnosis:	ICD 10 code:
Date of **Treatment**:	Estimated length of stay:
Proposed admission date (dd/mm/yyyy): / /	Proposed discharge date (dd/mm/yyyy): / /

Full details of proposed **Treatment**/surgery:

Procedure code (e.g. CPT, CCSD, DRG etc.)

Please provide total estimated costs including currency with breakdown of planned services as detailed below:

Surgeon's fee:	Room class:
Anaesthetist's fee:	Ward rounding fee x no. of days =
Operation theatre cost:	Standard room rate x no. of days =
Additional/Miscellaneous charges:	ICU rate x no. of days =

Package rate:

Total estimated charges as per above breakdown:

Section 4: Medical Practitioner Declaration

Medical Practitioner declaration:
I declare that I am the patient's **Medical Practitioner**, and that the particulars given are, to the best of my knowledge, true and correct.

Print name:

Signature:

Date (dd/mm/yyyy): / /

Official stamp:

Please notify **Us** by email or phone on +971 (0) 4450 1415 if additional **Treatment** is required, if the cost of **Treatment** and/or if the estimated length of stay is extended beyond the approved limit.

Section 5: Patient declaration and authorisation

Declaration

- I hereby declare that I am the patient/patient's guardian* (if the patient is under 16 years of age) (*please cross out if not applicable).
- I wish to claim **Benefit** and declare the information I have given is, to the best of my knowledge, true, correct and complete even if it is not in my own handwriting.
- I understand it is unlawful for me to knowingly provide false, incomplete or misleading facts or information (misrepresentations) to Now Health International forthe purpose of defrauding or attempting to defraud Now Health International or the **Underwriters**. Penalties may include imprisonment, fines, denial of coverage, loss of or increase in premium, loss of **Benefits** and legal damages.
- I agree to the data protection declaration above and understand that cover is provided in accordance with the terms and conditions of the WorldCare **Plan**.
- I have read the statement notifying me of my rights under the Access to Medical Reports Act 1988 and consent to Now Health International seeking medical reports if needed from my **Medical Practitioner**, so Now Health International can deal with my claim for **Benefit**.
- I do (NOT)* wish to see the medical report before it is sent to Now Health International. *Delete the word NOT if You wish to see the report.
- I hereby consent to authorise any Doctor and/or **Hospital** who has treated or advised me to provide Now Health International with any information they may require in connection with this claim.
- When completed and signed by the patient and **Medical Practitioner** (when appropriate), please return this form and the accompanying invoices and payment receipts to: Now Health International Gulf Third Party Administrators LLC, Ground floor, Al Shaiba Building, Dubai Outsource City, PO Box 502163, Dubai, UAE.
- I have read the declaration in Section 5.
- I agree to the declaration and understand that any claim for **Benefit** is in accordance with the terms and conditions of the **Plan**.

Patient's signature:

Date (dd/mm/yyyy):

/ /