Medical Claim Form / Pre Authorization

Please fill all sections and use separate form per member per visit.

A: Patient information (to be completed by member/patient/ guardian only)

Patient's Name: ..... Date of birth:..... Employee Name: .....Patients relationship with employee:.....

Company/ employer:..... Membership number:.....

Telephone No.....email.....

DECLARATION: I declare that to the best of my knowledge, all the information provided on this form is accurate, and understand that Amanah Insurance will rely on the information provided as such, I agree and accept that this declaration gives Amanah Insurance and its appointed representatives the right to request past, present and future medical information in relation to this claim or any other related claim, from any third party including providers and medical practitioners. I understand that any deliberate misrepresentation or the omission of any material facts may result in Hospital reserves the right to recover any costs directly from the plan holder or myself.

Member / guardian signature: ..... Date: .....

B: Clinical information (to be completed by attending Medical practitioner or consultant)

Name of Hospital:..... Tel & Fax No.....

Diagnosis: .....
....
.....
.....

Brief History and Findings: .....

FOR PREAUTHORIZATION ONLY					
Pre-Authorization Request for	☐ **Emergency In-patient** ☐ **Non-emergency In-patient** ☐ **Dental** ☐ **Optical** ☐ **M.R.I. (IP/OP)** ☐ **CT scan (IP/OP)** ☐ **Others** (Pls. Specify) **(IP/OP)**				
Admission Date		Length of Stay		Estimated Cost (in USD)	

Doctor's Name: ..... Tel. .....

I hereby confirm that the information provided above is correct and true to the best of my knowledge.

Date: ..... Doctor's Signature & Stamp: .....

C: Reimbursement Account Information

Name:.....

Account Name:.....

Account Number:.....