Insert Company Logo, if applicable

PRE-AUTHORISATION FORM TO BE COMPLETED BY ATTENDING DOCTOR
(Indicate "NA" if not applicable.)

Fill dates in format "DDMMYYYY"

Name of Patient	**NRIC / FIN No**

A. Details of Hospitalisation

Name of Principal Doctor and Clinic	**Name of Hospital / Surgery Centre**

Preferred Ward Type

Private

☐ Day Surgery ☐ 2 Bed
☐ Standard Single Bed ☐ 4 Bed
☐ Others:

Public/Restructured

☐ Day Surgery (subsidised) ☐ Class B1/B1+
☐ Day Surgery (non-subsidised) ☐ Class B2/B2+
☐ Class A ☐ Class C

Date of Admission	**Est. Length of Stay** (No. of days)

Is the condition typically managed on an outpatient basis? If Yes, please provide reason for this hospitalisation.

☐ No ☐ Yes, reasons are:

Date of first consultation of symptoms	**Date of diagnosis/ provisional diagnosis**	**Diagnosis / Provisional diagnosis in ICD 10 AM with description**

Date of onset of symptoms / Duration of symptoms	**Description of symptoms**

Did the patient come to see you with a referral letter?

☐ No ☐ Yes

(If a referral letter is available, please attach a copy to speed up the pre-authorisation process.)

Based on the information available to you, does the patient have any of the following major co-morbidities?
(Note: Only co-morbidities that have impact on the patient's treatment, impact on the duration of hospitalisation, or which are medically related to the patient's condition, need to be indicated.)

Based on the information available to you, is the event for which pre-authorisation is being requested:

☐ For a routine check-up/screening
☐ Related to a clinical trial/study
☐ Related to self-inflicted injuries/attempted suicide
☐ Related to alcohol/drug abuse
☐ Related to a congenital anomaly/genetic disorder
☐ Related to a mental/psychiatric disorder
☐ Related to an elective cosmetic procedure
☐ Related to a dental procedure
☐ Related to an STD or HIV/AIDS

Comorbidities	**Date of diagnosis, if available**
☐ Cancer	
☐ Stroke, Heart Failure, Cardiovascular Disease	
☐ Diabetes	
☐ Hyperlipidaemia	
☐ Hypertension	
☐ Kidney Failure	
☐ Other Significant Comorbidities that impact the patient's care (Please state):	

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

B. Best Estimated Costs	S$
1. Total Professional Fees Breakdown as:	.....

TOSP Code and Description:	
Surgeon fees	S$
Anaesthetist fees	S$

TOSP Code and Description:	
Surgeon fees	S$
Anaesthetist fees	S$

TOSP Code and Description:	
Surgeon fees	S$
Anaesthetist fees	S$

2. Total Attendance Fees		.....
3. Total of Other Fees (E.g. Secondary treating doctors' fees, surgical implants, medical consumables, and other charges.) Breakdown as:		
a.		S$
b.		S$
c.		S$
d.		S$
		.....
4. Total Hospital Charges		.....
5. Total Bill Size = 1 + 2 + 3 + 4		.....

C. Principal Doctor's Declaration & Signature

1. I represent and warrant that:

(a) I have personally examined and treated the Insured (i.e. patient) in respect of the medical condition described above and that the information stated above represent my genuine and honest opinion of his/her condition and my recommended treatment; and

(b) the answers given above are true, accurate and complete to the best of my knowledge and belief and that no information has been withheld.

2. I agree and authorize (name of insurer) to release this medical information, with the patient's consent if such disclosure is required by the Financial Industry Disputes Resolution Centre Ltd (FIDReC) of Singapore or any claim dispute resolution organisation.

Official Stamp of Hospital / Clinic

Name of Doctor: _____

Doctor's MCR: _____

Doctor's Signature and Date: _____

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