Aafiya

PRE-AUTHORIZATION FORM

Provider Name:	Patient Name:	
Insurance Company:	Patient Mobile No:	File No:
Company Name:	Member ID:	
Date Of Treatment: (dd/mm/yyyy)	Date Of Birth: (dd/mm/yyyy)	Gender:

Chief Complaints:		
Referral (if needed):		
Clinical Findings: BP: TEMP: HR: RR:		
Diagnosis:	Diagnosis Code:	Date of Onset: (dd/mm/yyyy)
PEC/CHRONIC ☐ CONGENITAL ☐ MATERNITY ☐ DENTAL ☐ OPTICAL ☐ WORK RELATED OTHERS ☐		

Out Patient Investigations/Treatment required:			
Laboratory:	Radiology:	Others:	Medicine/IV Fluids:
Estimated Cost:			

Cost Breakdown for Inpatient Services:	
Services	Total Amount
Room and Nursing Charges	
Procedure	
Consultation Fees	
Consumables	
Laboratory	
Radiology	
Pharmaceuticals	
Estimated Total Amount	

For Aafiya use only Approval Code:_____

In accordance to policy terms, conditions & exclusions:

Approved ☐ Partially Approved ☐ Rejected ☐ Pending ☐

No. of days:_____ Day case:_____

Copay: _____% Ded:_____

Remarks:

Approval valid up to 15 days as from: _____

Approval Officer: Date:

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.

Dr.'s Name: Stamp:

Signature: Date:

PATIENT'S DECLARATION:

I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history to Aafiya for purpose of determining insurance benefits.

Patient 's signature {Parent if minor}: Date:

Aafiya Medical Billing Services reserve its right during the Agreement period with the service provider, survey and audit the service provider's operations with respect to its performance of services, the patient visit details and claims.