ecare INTERNATIONAL

PRE-APPROVAL FORM

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A. ADMINISTRATION

Policy No:	Patient Name:
Policy Expiry: (DD)/ (MM)/ (YYYY)	Date of Birth: (DD)/ (MM)/ (YYYY)
Membership No:	Mobile No: / Gender: M | F
Group/Company Name:	Date of Visit:
Medical Provider Name:	Date of Treatment:

B. MEDICAL SECTION

Medical History:

First Date of Symptom:	Work Related Injury: Yes No
Diagnosis/Medical Condition:	IF SPECALIST REFERRAL REQUIRED Yes No

Proposed Treatment which needs approval:

C. PRE-AUTHORIZATION: (FOR E-CARE USE ONLY)

Details of Proposed Treatment/Surgery/Medicine: Estimated Cost:	As Per Related Documentation: Approve Not Approve
	Reference No:
	E-Care Stamp & Date:

I/We the undersigned, hereby declare that the particulars given herein are in every respect true and complete.

Doctors Name:		I hereby authorize the Medical Practitioner, Hospital/Clinics, Pharmacy, Lab to claim for me/my dependent (in case of children below 16 years) the medical service expenses and also to provide treatment details to E-Care International. I also confirm that if there is utilization excess or charges not covered in the policy, it will be borne by me/my company. Signature: Date:
Signature:		
Stamp:	Date:	

D. SPECIALIST/REFERRAL

Type of Treatment (Specialist):

CPT/Service Codes:	Itemized Cost	Consultation:
		Investigation:
		Treatment:

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Doctors Name:	I hereby authorize the Medical Practitioner, Hospital/Clinics, Pharmacy, Lab to claim for me/my dependent (in case of children below 16 years) the medical service expenses and also to provide treatment details to E-Care International. I also confirm that if there is utilization excess or charges not covered in the policy, it will be borne by me/my company. Signature: Date:
Signature:	
Stamp: Date:	