Advance Request Form

Request Type (select one)
- ☐ Pre-authorization
- ☐ Letter of Guarantee
- ☐ Other (additional details below)

Please complete this form and submit to GlobalHealth Asia at ghclaims@globalhealthasia.com. For non-emergency hospitalizations, you must file this form and supporting information at least 3 working days before the hospitalization.

SECTION A (completed by member)

Policy/Member Information

Patient Name:		Policyholder Name:
Policy Number:		Member Number:
Telephone:	Fax:	Email:

SECTION B *(To be answered by member or parent if a minor)*

If this claim pertains to illness

When and how did this illness first occur? When did you first consult a doctor about this problem or these symptoms?

Have you ever had a similar illness or similar symptoms? ☐ Yes ☐ No

Do you have other insurance which may cover this condition/treatment? ☐ Yes ☐ No

If yes to either question, please give full details below.

If this claim pertains to an injury:

Briefly describe how this injury occurred (include date, time and exact place):

Did this accident arise from your employment duties? ☐ Yes ☐ No
Was a third party involved? ☐ Yes ☐ No

If yes to either question, please provide additional details below and state whether compensation will be provided.

Space for additional details:

DECLARATION

I hereby declare that all information provided on this form together with any documents submitted herewith are true and correct to the best of my knowledge and belief.

I acknowledge that, unless otherwise agreed by the Company in writing, a letter of guarantee or pre-authorization of direct billing is not a confirmation of coverage for the condition or services, and that I remain responsible for charges not covered under the terms of the policy. If GlobalHealth guarantees and/or pays non-covered charges, I agree to reimburse GlobalHealth within 30 days after being notified of such non-covered charges.

Authorization for Release of Information

I authorize any doctor, hospital, or other health provider or facility, insuring or reinsuring company, or employer to release to the Insurer ("the Company") any information or records they may have regarding my health, tests or treatments I have received, and benefits or compensation therefor. If this claim relates to an accident, past or present, I also authorize any governmental body, agency, or other person or organization who may have records pertaining to such accident to release such records or information. I understand that information collected in connection with this letter of guarantee will be used by the Company in accordance with the Company's and GlobalHealth's privacy policies and will not be used for any direct marketing purpose. I agree that a photocopy or facsimile of this release shall be as effective as the original.

Signature of Member (Parent) Date

Patient Name:	Policy Number:

SECTION C *(to be completed by attending physician)*

Medical and Admission Information

Reason for hospitalization/procedure (symptoms and diagnosis/differential diagnosis)		
Date the patient first consulted you about this condition or symptoms		Date symptoms arose
Are you the first medical practitioner the patient has seen about this condition or symptoms?	☐ Yes ☐ No (explain)	
Is this the first time the patient has experienced these symptoms or suffered from this condition?	☐ Yes ☐ No (explain)	
Brief summary of treatment plan including procedure(s) (if any):		
What tests or procedures have been done prior to this hospitalization (attach results if applicable)		
Hospital Name (include contact details if outside of Hong Kong)		
Planned Admission Date:		
Estimated Length of Stay		
Estimated Costs (please indicate currency):	Professional Fee	
	Other Charges	

Attending Physician Name:		
Address:		
Tel:	Fax:	Email:

Signature of Attending Physician Date

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