WorldCare pre-authorisation request form

When submitting a pre-authorised claim to **Us**, please return this form with a completed claim form and any supporting documents.

This form should be completed by **Your** treating **Medical Practitioner**.

Please send **Your** completed form to **Us** via **Your** intermediary or direct to Now Health International (Asia Pacific) Limited, Suite B, 33/F, 169 Electric Road, North Point, Hong Kong. **You** can also scan and email it to AsiaPacService@now-health.com or fax it to +852 2279 7330.

Section 1: Medical facility details

Medical facility:		
Email:	Fax:	Telephone number:
Treating **Medical Practitioner**:		
Email:	Fax:	Telephone number:
Patient name:		
Membership number:	Date of birth(dd/mm/yyyy): / /	

Section 2: Approval request (please tick appropriate box)

Elective **Treatment**		
In-Patient ☐	**Day-Patient** ☐	**Out-Patient** surgery ☐
Physiotherapy ☐	PET ☐	Maternity ☐
USA **Treatment** ☐		

Other **Treatment**		
Emergency admission ☐ Please provide full details of nature of illness and **Treatment**:		
Accident ☐ Please provide details of cause, date and place of **Accident**:		
Was a third party involved? if yes, please give details:		
Mortal remains ☐	Psychiatric **Treatment** ☐	AIDS ☐
Other ☐ Please specify:		

Section 3: Treatment details

Full details of condition requiring **Treatment:**	
Date the patient first became aware of any signs or symptoms of this condition (dd/mm/yyyy): / /	
Date on which the patient first presented to any doctor for this condition (dd/mm/yyyy): / /	
Underlying cause (if known):	
Provisional diagnosis:	ICD 10 code:
Date of **Treatment**:	Estimated length of stay:
Proposed admission date (dd/mm/yyyy): / /	Proposed discharge date (dd/mm/yyyy): / /
Full details of proposed **Treatment**/surgery:	
Please provide total estimated costs including currency with breakdown of planned services as detailed below:	
Package rate:	Standard room rate x no. of days =
Surgeon's fee:	ICU rate x no. of days =
Anaesthetist's fee:	Estimated medical charges as per breakdown:
Theatre costs:	
Additional charge(s):	
Total estimated costs:	

Section 4: Declaration

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.	Official stamp:
Print name:	
Signature:	
Date (dd/mm/yyyy): / /	

Please notify **Us** by email or phone on +852 2279 7310 if additional **Treatment** is required, if the cost of **Treatment** and/or if the estimated length of stay is extended beyond the approved limit.