Pre-certification Medical Form

GOODHEALTH

Goodhealth Claims Service - HK
Office Hour Tel:
(852) 2860 8000
24-Hrs emergency Hotline:
(852) 2970 3045
Email: claims@goodhealth.com.hk

To:	From: Goodhealth Worldwide (Asia Pacfic)
Limited	
Fax No:	Fax No:
Tel No:	Tel No:
Date:	Pages: 1 of

Insured:	Date of Birth:
Policy No:	Claim No:
Location:	Contact No:

To be completed by treating physician

Treating Physician:	Referring Doctor:
Tel No:	Tel No:
Fax No:	Fax No:
E-mail:	E-mail:
Admitting Hospital:	Admission Date:
Medical Facility:	Discharge Date:
Tel No:	Contact Person:
Fax No:	

To be completed by treating physician

Condition requiring Treatment: _____
Please advise if a chronic condition

Underlying Cause: _____

First Consultation date __/__/___ Symptoms apparent from ___/___/____

Has this or any similar condition existed previously? ☐ No ☐ Yes (if Yes please attach details)

Proposed Treatment/Procedure _____

Medication currently taken _____

Admit as: In-patient / Day patient / Out-patient

Proposed admission date: __/__/___ Estimated length of stay: _____

Cost Estimate (to be completed by all relevant parties)

Surgeons fee (approx.) _____ Anaesthetists Fee (approx.) _____

Room Rate _____ Hospital Charges (approx.) _____

Agreed Fee _____ Prompt Payment Discount _____

Package Cost _____ Class of Room _____

Signature Doctor / Hospital Authority _____ Date ___/__/__

Please return by fax to **+852 2866 2555** (Office Hour) / +852 2528 9933 (Non-office Hour) or e-mail to claims@goodhealth.com.hk along with full medical reports held in respect of the patient and any laboratory test results.