OLDMUTUAL

PRE - AUTHORISATION FORM

Please complete this form and return/ Email immediately or within 24 hours after admission

Full name of Patient____

Full name of Member_______________________ Company Name_______________________

Tel No. _______________________ Member No. _______________________

ID Card No. _______________________ Date of Birth _______________________

Admitting Hospital _______________________ Date of Admission _______________________

Hospital/Doctor's Email ____

Admitting/Attending Doctor _______________________ Specialty _______________________

Tel No._______________ Mobile No. _______________ Email _______________________

Diagnosis: ____

Underlying condition (if any) ____

When was the condition first diagnosed? ____

Is the condition congenital? ____

Name of operation required if any____

- Please indicate if Surgery is under Local Anesthesia or General Anesthesia_______________________
- Doctor's Fee____

Clinical Summary (Mandatory Field)

History____

____

Main Investigation and findings ____

☐ MRI ☐ CT Scans ☐ Ultrasounds ☐ Blood works ☐ Others

Specify:

____

Management Plan ____

Doctor's Signature _______________________ Date_______________________

DECLARATION
I warrant the truth of the above statements. I have not withheld or misstated material information relating to this claim and have no objection to yourselves communicating with my medical doctor with regard to this claim.

Member's Signature_______________________ **Date**_______________________