

Administered by:



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# 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 Arabia Insurance Company S.A.L., c/o Now Health International Gulf Third Party Administrators LLC, Unit 3701, Burj Al Salam Building, 3 Sheikh Zayed Rd, PO Box 334337, Dubai, United Arab Emirates. **You** can also scan and email it to [ClinicalService@now-health.com](mailto:ClinicalService@now-health.com).

## 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:



There is a legal requirement, in certain circumstances, to disclose information to law enforcement agencies relating to suspicions of fraudulent claims and other crimes. If required, information will be disclosed to third parties including other insurers for the purposes of prevention or investigation of crime including fraud or otherwise improper claims where there is reasonable suspicion. This may involve adding non-medical information to a database that will be accessible to other insurers and law enforcement agencies. Additionally, the General Medical Council or other relevant regulatory body will be notified about any issue where there is reason to believe a **Medical Practitioner's** fitness to practice may be impaired.

Please contact our Customer Services team or write to us at the address on the back of this form if **You** wish Now Health International group companies to contact You via letter, SMS or email with details of other IPMI or related product and services. A list of Now Health group companies, their contact details and **Our** Data Privacy Policy is available at [www.now-health.com/privacy](http://www.now-health.com/privacy)

**Your** health claims information may be shared by Now Health International Group companies to other Insurance Companies or Reinsurance Companies for the purposes of risk management, contract negotiations, research, development and analysis, as well as, to promote other products that may be of interest to **You**.

## Section 5: Medical Practitioner 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.

Print name:

Signature:

Date (dd/mm/yyyy):                    /                    /

Official stamp:

Please notify **Us** by email or phone on +971 (0) 4450 1410 if additional **Treatment** is required, if the cost of **Treatment** and/or if the estimated length of stay is extended beyond the approved limit.

## Section 6: Patient declaration and authorisation

### Declaration

- I hereby declare that I am the patient/patient's guardian\* (if the patient is under 16 years of age) (\*please cross out if not applicable).
- I wish to claim **Benefit** and declare the information I have given is, to the best of my knowledge, true, correct and complete even if it is not in my own handwriting.
- I understand it is unlawful for me to knowingly provide false, incomplete or misleading facts or information (misrepresentations) to Now Health International for the purpose of defrauding or attempting to defraud Now Health International or the **Underwriters**. Penalties may include imprisonment, fines, denial of coverage, loss of or increase in premium, loss of **Benefits** and legal damages.
- I agree to the data protection declaration above and understand that cover is provided in accordance with the terms and conditions of the WorldCare **Plan**.
- I have read the statement notifying me of my rights under the Personal Data Protection Act and consent to Now Health International seeking medical reports if needed from my **Medical Practitioner**, so Now Health International can deal with my claim for **Benefit**.
- I do (NOT)\* wish to see the medical report before it is sent to Now Health International. \*Delete the word NOT if You wish to see the report.
- I hereby consent to authorise any Doctor and/or **Hospital** who has treated or advised me to provide Now Health International with any information they may require in connection with this claim.
- When completed and signed by the patient and **Medical Practitioner** (when appropriate), please return this form and the accompanying invoices and payment receipts to: Now Health International Gulf Third Party Administrators LLC, Unit 3701, Burj Al Salam Building, 3 Sheikh Zayed Rd, PO Box 334337, Dubai, United Arab Emirates.
- I have read the important notes and the declaration.
- I agree to the declaration and understand that any claim for **Benefit** is in accordance with the terms and conditions of the **Plan**.

Patient's signature:

Date (dd/mm/yyyy):

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