NOW HEALTH INTERNATIONAL

SimpleCare 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 (UK) Limited, Suite 2.3, Building Three, Watchmoor Park, Camberley, Surrey, GU15 3YL, United Kingdom. **You** can also scan and email it to ClinicalService@now-health.com or fax it to +44 (0) 1276 602120.

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)

2.1 Third party insurers

Are some of the costs recoverable from a third party (for example, if the **Benefits You** are claiming relate to a **Medical Condition** or injury caused by a person or organization, or if **You** have cover on another insurance policy for this claim) Yes ◯ No ◯

If yes, name of third party insurer:

Does the patient hold another insurance policy for this claim? Yes ◯ No ◯

If yes, name of the Insurer:

2.2 Treatment

Emergency ◯ **Accident** ◯ **Elective** ◯

In-Patient ◯ *Day-Patient* ◯ *Out-Patient surgery* ◯

2.3 Complete this section if you are filing a claim because of an **Emergency** or **Accident**

1. If **Emergency**, please describe the nature of illness and underlying cause.

2. If **Accident**, please provide a brief synopsis on the **Accident** (how, where and when it took place)

Was a third party involved? if yes, please give details:

Section 3: Treatment details (Treating **Medical Practitioner** complete this section)

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:	
Procedure code (e.g. CPT, CCSD, DRG etc.)	
Please provide total estimated costs including currency with breakdown of planned services as detailed below:	
Surgeon's fee:	Room class:
Anesthetist's fee:	Ward rounding fee x no. of days =
Operation theatre cost:	Standard room rate x no. of days =
Additional/Miscellaneous charges:	ICU rate x no. of days =
Package rate:	
Total estimated charges as per above breakdown:	

Section 4: 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.	Official stamp:
Print name:	
Signature:	
Date (dd/mm/yyyy): / /	

Please notify **Us** by email or phone on +44(0) 1276 602110 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 5: Patient declaration and authorisation

Data Protection

We and the **Underwriters** will collect certain information about **You** in the course of considering **Your** claim. This information will be processed for the purposes of meeting **Our** legal and regulatory obligations and administering **Your** claim.

The information **We** collect about **You** includes details such as **Your** name and address as well as more sensitive details such as information about **Your** health.

The way **Your** cover works means **Your** information may be shared with and used by a number of third parties, including **Underwriters**, **Medical Practitioners**, Medical Assistance Companies and Claims Administrators – but only in connection with **Your** claim.

Want more details?

For more information about how **We** use **Your** personal information please see **Our** full privacy notice, a copy of which is available online at www.now-health.com or on request.

Contacting Us and Your rights

You have rights in relation to the information **We** hold about **You**, including the right to access **Your** information. Please contact **Us** at hello@now-health.com if **You** wish to exercise **Your** rights, discuss how **We** use **Your** information or request a copy of **Our** full privacy notice.

Access to Medical Reports Act 1988

It may be necessary to obtain a medical report from **Your** usual Doctor/**Medical Practitioner** for this claim. If **We** need to do this, this Act gives **You** specific rights and they are set out below. If **You** wish:

1. **You** can refuse to give **Your** consent – but if **You** do **We** may be unable to deal with **Your** claim.
2. **You** can ask to see the report before it is sent to **Us**. If **You** give **Your** consent, **We** will be able to contact **Your** Doctor direct for a report. If **You** wish to see it, delete the word "NOT" in the declaration and **We** will inform the Doctor accordingly. Then the Doctor will not send it to **Us** until:
   (i) **You** have seen the report and approved it; or
   (ii) 21 days have passed since **We** requested the report and the Doctor has not heard from **You**.

Important note: The sooner We receive the report, the sooner We can deal with Your claim.

3. Having seen the report, **You** can refuse **Your** consent – again this may affect **Our** ability to deal with **Your** claim.
4. **You** may ask the Doctor to change the report if **You** disagree with it. If (s)he refuses, **You** can require him/her to attach a statement of **Your** views to the report.
5. **You** may also ask the Doctor to let **You** see all reports supplied to **Us** within the last six months.

Important note: Your Doctor is entitled to charge You for supplying You with a copy of the report (to cover cost). This is not covered by Your Plan/ membership of Your employer's Group Plan.

Your Doctor may refuse to let **You** see **Your** report if (s)he feels it will do serious harm to **Your** physical or mental health, or it will indicate the Doctor's intentions in respect of **You**, or it may reveal the identity of another person who has supplied information about **You** who is not a health professional but is involved in **Your** care. In such cases **You** will be entitled to see the remainder of the report. If this affects the entire report, **Your** Doctor must obtain **Your** consent before (s)he sends it to **Us**.

Sanctions Limitation and Exclusion

We will not provide cover nor pay claims under this **Plan** if **Our** obligations (or the obligations of **Our** group companies & administrators) under the laws of any relevant jurisdiction including UAE, UK, European Union, the United States of America, United Nations resolutions, trade or economic sanctions or international laws sanctions, prevents or restricts **Us** from doing so.

We will not provide You with any services or benefits including but not limited to acceptance of premium payments, claim payments and other reimbursements if in doing so, **We** violate applicable law, regulation, code or court order or are or will be otherwise sanctioned, prevented or restricted.

We may terminate Your Plan if **We** consider **You** or **Your** directors or officers as sanctioned persons, or **You** conduct an activity which is sanctioned, according to trade or economic laws & regulations.

Important note: We regard the rights above as best practice but the legal requirements may differ in the country in which You reside. Please contact Us for additional information regarding regulations in Your jurisdiction.

By signing this Application Form **You** consent to the processing and transfer of information (including sensitive information) described in this notice. Without this consent **We** will not be able to consider **Your** application.

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 Now Health International **Plan**.
- I have read the statement notifying me of my rights under the Access to Medical Reports Act 1988 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 (UK) Limited, Suite 2.3, Building Three, Watchmoor Park, Camberley, Surrey, GU15 3YL, United Kingdom.
- I have read the declaration in Section 5.
- 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): / /