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 Limited, PO Box 482055, Dubai, UAE. **You** can also scan and email it to 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)

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 +971 (0) 4450 1510 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 administering claims. **Your** information may be passed to **Underwriters**, **Medical Practitioners,** Medical Assistance Companies and Claims Administrators for these purposes. The same duty of confidentiality is required of any third parties to whom the administration of **Your Plan** may be subcontracted. **Your** name and contact details will not be disclosed to other organisations (except as stated above).

It may be necessary to obtain a medical report from **Your** usual Doctor/Medical Practitioner for this claim. If **We** need to do this, You have the following rights:

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.

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.**

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.

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 with regards to access to medical reports 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 Limited, PO Box 482055, Dubai, UAE.
- 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): / /