# 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 Now Health International Services (Europe) Limited, Dragonara Business Centre 5th Floor, Dragonara Road, St Julian's, STJ 3141, Malta. **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)

| Elective **Treatment** | | |
|---|---|---|
| **In-Patient** ☐ | **Day-Patient** ☐ | **Out-Patient** surgery ☐ |
| Physiotherapy ☐ | PET ☐ | Maternity ☐ |
| USA **Treatment** ☐ | | |

| Other **Treatment** |
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| **Emergency** admission ☐ Please provide full details of nature of illness and **Treatment**: |
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| |
| **Accident** ☐ Please provide details of cause, date and place of **Accident**: |
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| |
| Was a third party involved? if yes, please give details: |
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| Mortal remains ☐ | Psychiatric **Treatment** ☐ | AIDS ☐ |
| Other ☐ Please specify: | | |

## Section 3: Treatment details

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: |
| Anaesthetist'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.

Print name:

Signature:

Date (dd/mm/yyyy): / /

Official stamp:

Please notify **Us** by email or phone on +356 2260 5110 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

Please ensure that **You** show the following information to others covered under **Your Plan** or make them aware of its contents.

**We** and the **Underwriters** will deal with all personal information supplied in the strictest confidence as required by the Data Protection Act. **We** and **Your Underwriters** collect personal information about **You** and **Your Dependents** (including health, bank account and occupation) for the purpose of establishing and administering **Your Plan**. This includes information supplied by **You**, those family members, medical providers or **Your** employer (if applicable). **Your** information may be passed to Now Health group companies administrating **Your Plan**, **Underwriters**, Insurers, Reinsurers, Medical Practitioners, Medical Assistance Companies and Claims Administrators for these purposes, including those located outside **Your** country of residence. Confidentiality is required of any third parties to whom the administration of **Your Plan** may be subcontracted, including those based outside the country of **Your** residency. In certain circumstances, medical service providers (or others) may be asked to supply further information. **Your** personal details will not be disclosed to other organizations without **Your** consent.

**You** have a right of access to, and correction of, information that **We** hold about **You**. Please contact **Us** if **You** would like to exercise either of these rights. Some of the information **We** collect about **You** may be classified as "sensitive" – that is information about racial or ethnic origin and physical or mental health. Data protection laws impose specific conditions in relation to sensitive information, including, in some circumstances, the need to obtain **Your** explicit consent before **We** process the information. When **You** provide information about family members, **We** will take this as confirmation that **You** have their consent to do so. As the legal holder of the **Plan** all correspondence about the **Plan**, including claims correspondence, will be sent to the **Planholder**. If any family member over 18 insured under the **Plan** does not want this to happen they should apply for their own **Plan**.

When **You** provide information about **Your Dependants** or employees and their **Dependants**, **You** represent and warrant that **You** have obtained consent from **Your** employees and their **Dependants** to provide and receive information about their personal information and the cost of their medical insurance **Plan**, but not of medical condition.

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 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.

**We** need **Your** consent to use **Your** contact details for this purpose, which **We** will ask for before **We** start sending **You** any marketing communications. **You** do not have to give **Your** consent and **You** may withdraw **Your** consent at any time by contacting **Our** customer service at CustomerService@now-health.com or write to **Us** at the address on the back of this form.

**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**.

### Access to Medical Reports Act 1988

It may be necessary to obtain a medical report from **Your** usual Doctor/**Medical Practitioner** in connection with **Your** application to become a member under **Your Plan**. 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** application.
2. **You** can ask to see the report before it is sent to **Us**. If **You** give **You**r 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 application for membership.**

**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 Malta, 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 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 Services (Europe) Limited, Dragonara Business Centre 5th Floor, Dragonara Road, St Julian's, STJ 3141, Malta.
- 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): |
|---|---|
| | / / |