Pre-certification Medical Form（医疗预先批核表）

Aetna International

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Member's Basic Information (客户基本信息)

Name of Member (姓名)		Date of Birth (出生日期) M M D D Y Y
Policy Number (保单号)	Member ID (客户号)	Patient's Phone Number (电话)

Provider Information (医院信息)

Name of Facility (医院名称)		
Address of Facility (医院地址)		
Name of Attending Physician (主治医生)	Provider Contact Name (联系人姓名)	
Fax Number (传真)	Phone Number (电话)	E-mail (邮件地址)

Medical Condition - to be completed by attending physician (医学病史–由主治医师填写)

Diagnosis (诊断)		
Please advise if a chronic condition (是否是慢性病)	Underlying Cause (病因)	
First Consultation Date (首次就诊日期) M M D D Y Y	Symptoms apparent from (症状开始时间) M M D D Y Y	
Pre-existing: (if Yes please attach details 如果是请提供相关信息) ☐ Yes ☐ No	Related Illness History (相关疾病过去史)	
Treatment / Procedure (诊疗方案)		
☐ In-patient (住院) ☐ Day patient (日间留院) ☐ Out-patient (门诊)	Admission Date (住院日期) M M D D Y Y	Estimated Length of Stay (住院天数)

Cost Estimated (预算)

Surgeons Fee (医生费用)	Ward Round Fee (巡房费) per day(每天)	Anesthetists Fee (麻醉费)
Room Rate (病房费)	Class of Room (病房等级)	Package Cost (套餐费)

Hospital Charges (医院费用)	Other Cost (其它费用)	Total cost（总费用）

Doctor Signature / Hospital Authority (医生/医院签名)	Date (日期) M M D D Y Y

Note: Please submit any supporting medical documentation along with this completed Pre-authorization Form. Failure to complete and submit this form could result in substantial penalties for the client (备注：请将所有相关的医学资料与填写完整的事先授权表一起递交. 如果没有填写事先授权表或者重要信息缺失,可能给客户造成不必要的损失).