MSH CHINA

Pre-Authorization Request Form（事先授权表）

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Return Fax Number/传真**: 86-21-6160-0209**
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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 #(传真):______________________

Phone #(电话): _____________________________ E-mail(邮件地址): ______________________

Patient's Basic Information (病人基本信息)

Name of Patient(病人姓名): ____

Date of Birth (出生日期)____

Member ID(客户号):____

Patient's Phone #(电话):____

Medical Condition (医学病史)

***Note: If all medical records & related examination reports are presented to us, you can ignore this part (**备注：如果相关医疗病史及检查报告已同时提交，该部分可以不填写**)**

Medical Diagnosis(医疗诊断): ____

Physical Exam Result(体格检查结果): ______________________________________

Lab Test Results(实验室检查结果): _______________________________________

Past Medical History (既往病史)

Related Illness History(相关疾病过去史): __________________________________

Failed Conservative Medical Management (经历的未成功的保守治疗方案):

____

____

Procedure (步骤):

Expected Date of Procedure(预计日期): ___________________________________

Expected Procedure(预计治疗): a. Outpatient Exam/Surgery(门诊检查/手术) _______________

b. Inpatient Treatment(住院治疗):_________________________

c. Delivery(生育): ________________________________

Expected Length of Stay(预计住院总天数): _________________________________

Date of Operation(手术日期): ____

Name of Operation(手术名称): ____

Estimated Cost(估计费用**)**: US$ _____________________/ RMB ______________________

If Assistant Surgeon is needed, please provide notes explaining medical necessity(如还需别科（院）医生会诊，联合手术，请阐释医学必要性):

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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**)**.