PPP INTERNATIONAL

redefining / healthcare

Pre-Approval Request

This form will allow us to:

1. Review your claim and ensure we have all the information needed to issue our guarantee of payment.
2. Carry out checks or audits to ensure the information that has been sent to us is correct.

Please complete this form in block capitals.

Patient details

Customer number:

Patient's name:

Claim number:

Patient's date of birth:

Patient's telephone number:

Patient's email address:

1. Declaration and consent (to be completed by the patient)

I confirm I have read the information in this form.
I wish to make a claim and declare that all the information I have given you is, to the best of my knowledge, true and correct.

- I consent to AXA PPP Healthcare reviewing the information on this form
- I consent to AXA PPP Healthcare requesting medical information, if needed, from the patient's medical practitioner and/or hospital.
- I consent to the medical practitioner and/or hospital providing medical reports and access to copies of such health records as may be requested by AXA PPP Healthcare. This is so that AXA PPP Healthcare limited can:
  a. **Deal with the application/claim for benefit;**
  b. **Undertake audits and other investigations; and**
  c. **Process and share medical information with third parties where there is a legal requirement to do so.**
- I consent to AXA PPP Healthcare reviewing the information in any medical reports or health records that may be requested.
- I consent to the medical practitioner, and/or hospital involved in the patient's care reviewing medical or treatment details and discharge arrangements with AXA PPP Healthcare.

I agree that AXA PPP Healthcare will send all further correspondence about this claim to the policyholder, unless I ask you not to.

3.1 **I declare** that I am the patient
☐ Yes ☐ No

3.2 **Is the patient under 16** years of age?
☐ Yes ☐ No

3.3 **If yes, I declare** that I am the patient's parent/guardian
☐ Yes ☐ No

3.4 **I wish** to see any report from the medical practitioner before it is sent to you.
☐ Yes ☐ No

3.5 Signed*:

(*To be signed by the patient or parent/guardian if the patient is under 16)

Date:

3.6 Patients full name

2. Medical details (To be completed by the patient's medical practitioner)

2.1 If claim is related to a pregnancy:

Is the pregnancy following any form of infertility treatment conception? ☐ Yes ☐ No

2.2 Medical condition requiring consultation/treatment & symptoms:

2.3 How long has the patient had symptoms prior to visiting the medical practitioner?

2.4 The date your patient first presented to any medical practitioner?

2.5 Please give a full history of the medical condition requiring treatment, including details of any previous and current investigation/treatment/medication together with any relevant dates.

2.6 Please confirm if the patient has sought treatment or advice with any medical practitioner, or received any medication, or followed any special diet over the two years prior to the date this episode started.

☐ Yes ☐ No If yes, please give details below

2. Medical details (To be completed by the patient's medical practitioner) continued

2.7 Please give any other medical history relevant to the condition being claimed for.

2.8 Please give treatment plan, **including intended length of stay and name of surgery.**

2.9 Please give details of the treatment provided **so far** for the medical condition being claimed for.

3. Hospital Details & Costs:

Hospital name & contact details:

Admission date :

Discharge date :

Breakdown of estimate of charges:

Daily Bed Rate

3. Hospital Details & Costs continued:

Surgical cost:

Specialist:

Additional costs – please specify:

Total Cost of Admission:

I am the patient's medical practitioner and confirm the information I have provided is correct to the best of my knowledge. I understand that the accuracy of the information provided may affect my patient's claim for private treatment.

Medical practitioner's signature:

Date:

Practitioner's stamp:

Print Name:

Telephone:

Fax:

Email:

Please return this form to:

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