InterGlobal Pre-Authorisation Form – Non Maternity (In-patient and Daycare only)
Treating Specialist / Consultant or Hospital Insurance Office to Complete
*****To ensure efficient processing of this application please ensure the form is completed clearly and legibly*****

Patient's Family Name: First Name:

Patient's Date of Birth: / /

Plan Name: Plan Number: Member Number:

Patient's Contact Phone Number:

Patient's email address (if known):
NB: Contact details must be provided to enable us to process the pre-authorisation, failure to do so may result in delays.

Name of the hospital admitting/admitted:

Admission Date: Discharge Date: Expected Length of stay (no. of days):

NB: Admission date must be provided before we can provide a Guarantee of Payment letter

Specialist / Consultant Name: In-house Doctor ☐

Community / Visiting Doctor ☐

Specialty: Clinic Name:

Telephone number:

Fax Number:

E-mail Address:

If the patient was referred to you – please advise the name and contact details of the referring doctor.
Name of Doctor: Contact telephone number:

On what date did this patient first register with you: / /

On what date did the patient first notice signs and symptoms of this medical condition prior to consulting with you?
/ /

On what date did the patient first present these symptoms to you: / /

Please provide full details of patient symptoms:

Has the patient suffered from the same or similar symptoms previously:

Yes: ☐ No: ☐
If yes, please provide full details:

Please provide full details of medical examination and investigation findings:

What is the diagnosis (if known):

Is this diagnosis: Provisional ☐ Final ☐

Please provide us the information if the patient is suffering from any additional medical conditions which could complicate this condition.

In Your opinion would you consider the medical condition to be:

Acute: ☐ Chronic: ☐

Acute episode of a chronic condition: ☐ Terminal ☐

Please state and attach copies of all histological, biopsy, MRI, CT-Scan, and other relevant hospital reports, laboratory and tests results completed to date.

Please provide the proposed treatment:

Surgical Procedure Name:

CPT / Operation code:

Please provide investigations required:

1. 5.
2. 6.
3. 7.
4. 8.

Estimated Costs

Please provide a breakdown amount in point a-f if you do not provide package prices, or please advise the package quote in point g.

Doctor's/ surgeon's fee:

Doctor's daily attendance fee (ward):

Doctor's daily attendance fee (ICU):

a) Anaesthetist's Fees:

b) Laboratory Fees:

c) Radiology Fees:

d) Hospital Theatre Fees:

e) Medicines/consumables:

f) Estimated package price if applicable:

I declare that to the best of my knowledge and belief the statements made on this claim for are full, true, and complete

Attending Doctor's Name, Signature & Stamp:

Date: / /

Please note: If the patient is on a Moratorium Policy, we may need to obtain further details of previous medical history, before being able to approve costs for this medical treatment. Your assistance in providing this form, fully completed, **at least 48 hours** prior to discharge, is much appreciated.

Please return this form to the following
Fax Number: +44 (0) 1252 351202
E-mail Address: assistance@interglobalpmi.com