

REQUEST FOR LETTER OF GUARANTEE

All details in this form are to be duly completed and signed by both the doctor and the insured member.

Your Letter of Guarantee request should be submitted at least 7 days ahead by your scheduled treatment. The earlier the better helps in case additional information is needed.

For admission to Private Hospital, Page 2 of this form is to be completed by the Attending Physician.

For admission to Government/Restructured Hospital, please provide relevant documents such as Hospital Financial Counselling/Admission Forms.

Please submit this form prior to the surgery or procedure, together with any full medical report(s) or laboratory test result(s) to

- Fax : 6715 9429
- Email : aetna@ihp.com.sg
- Hotline : 6715 6446

Particulars of Insured Member

Name of Employee : _____ NRIC / Passport No: _____
Name of Patient : _____ NRIC / Passport No: _____ Relationship: _____
Name of Employer : _____ Policy No : _____
Date of Employment: _____ Contact No : _____
Email Address : _____

Declaration & Authorisation

- I hereby authorise, agree and consent to:
 - Insurer and Integrated Health Plans Pte Ltd to request from any hospital, physician, person or organisation, all information with respect to any illness, injury, medical history, and copies of all hospital or medical records concerning myself or dependants at any time and authorise the prior mentioned organisations to disclose all such information to Insurer and Integrated Health Plans Pte Ltd.
 - Insurer and Integrated Health Plans Pte Ltd collecting, using, and/or disclosing my personal data for the processing of pre-authorisation and such other purposes ancillary or related to the administering of my insurance coverage and claims adjudication.
- I agree that Insurer and Integrated Health Plans Pte Ltd and my Employer reserve the right to recover any outstanding amount should my total medical expenses exceed the policy coverage and/or is not covered under the policy.
- I hereby declare that all the information, above statements and answers including any attachments related to it are true and complete. I have not withheld any material fact from Insurer, Integrated Health Plans Pte Ltd and my Employer.
- This declaration and authorization shall bind my/our successors and assignees, and remains valid, notwithstanding death, irrespective of whether or not our claim is accepted by Insurer and Integrated Health Plans Pte Ltd. I agree that a photocopy of this authorisation shall be considered as effective and valid as the original.

Signature of Employee: _____

Signature of Patient / Guardian if patient is below 21 years old: _____

Date: _____

Disclaimer

This request for letter of guarantee does not guarantee the acceptance, application or availability of insurance. The content of this form has been compiled by Integrated Health Plans Pte Ltd and is subject to the terms, conditions and exclusions of the regulated insurer's policy wording which may change from time to time. Refer to the relevant policy document for complete and most up to date details. Integrated Health Plans Pte Ltd will not be held liable for the contents of this form, its existence or any representations made in its connection.



To be completed by Attending Doctor/Surgeon

For admission to Private Hospital, patient must arrange to have this section completed by the Attending Physician.

For admission to Government/Restructured Hospital, please provide relevant documents such as Hospital Financial Counselling/Admission Forms.

1. Particulars of Attending Doctor/Surgeon

Doctor/Surgeon: _____

Referring Doctor: _____

Clinic Name: _____

Clinic Address: _____

2. Details of Surgery/Procedure

Hospital Name: _____

Admission Date: _____

Date of Surgery: _____

Surgical Code: _____

Surgical Procedure: (Surgical Code) _____

Estimated Length of Stay: _____

3. Condition Requiring Treatment

Symptoms: _____

Symptoms Apparent from: _____

Underlying causes(s) of the condition being treated (If this is an injury, please indicate how the injury was sustained):

Final Diagnosis of Illness or Extent of Injury: _____

Diagnosis Date: _____ First Consultation Date: _____ ICD 10 Code: _____

a) Has this or any similar condition existed previously? NO YES
If yes, please attach details and proceed to next question

b) Has the patient had any prior treatment for this condition? NO YES
If yes, please state date of treatment, name and address of doctor who treated the patient

4. Is the condition of patient due to or related to:

- Congenital anomaly/Genetic/Chromosomal Disorder? NO YES
- Psychological, mental or emotional disorder? NO YES
- Dental/gum treatment or oral mucosal? NO YES
- Pregnancy, childbirth, sub-fertility or infertility? (Date of last menstruation _____) NO YES
- Self-inflicted injury, drug addition, alcoholism? NO YES
- Routine check-up / screening? NO YES
- Obesity / weight reduction? NO YES
- Cosmetic? NO YES
- STD/HIV/AIDs? NO YES
- Gender reassignment? NO YES

5. Admit as: IN-PATIENT DAY-SURGERY



6. Estimated Cost of Admission:

*Please list down below all the surgical procedures with breakdown of individual charges if more than one will be performed:

	Estimated Cost (Exclude GST)	Required Information (Please provide in separate sheet if space is insufficient):
*Surgeon Fee	: _____	Surgical Procedure: _____ Surgical Code: _____
*Surgeon Fee	: _____	Surgical Procedure: _____ Surgical Code: _____
*Surgeon Fee	: _____	Surgical Procedure: _____ Surgical Code: _____

*Description of Surgical Procedure with no surgical code

Dr's Attendance Fees	: _____	Rate SGD _____ /day x No. of Days: _____
Room & Board	: _____	Rate SGD _____ /day x No. of Days: _____
Anesthetist's Fees	: _____	
Hospital Charges	: _____	
Clinic Consumables	: _____	Breakdown of Charges: _____
Implant(s) Cost	: _____	Breakdown of Charges: _____
Total Estimated Cost	: _____	

Doctor/ Surgeon's Signature : _____ **Date** : _____

Clinic/ Hospital Stamp : _____

