

## Prior agreement application Hospitalization

Hospitalization expenses will only be reimbursed by Henner if the Medical Advisory Board has granted a prior agreement based on the information in this document, **which must be completed by the Physician and sent by post, fax or email to:**

**Henner Medical Advisor**  
14 boulevard du Général Leclerc  
CS 20058 – 92527 Neuilly-sur-Seine Cedex – France

**Fax:** +33 (0)1 85 64 74 15  
**Email:** medical@henner.com

This form must be sent **no later than 10 days prior to the date of hospitalization**, with any supporting documents (MRI scans, X-rays, laboratory reports). In the event of a medically **justified emergency**, this form must be sent within **3 days following admission**.

**If the Medical Advisory Board approves the hospitalization, a guarantee of payment will be issued and sent directly to the designated institution.** The Medical Advisory Board will notify the patient in the event of a refusal.

**Insured member's first and last name:**

**ID Number:**

**Patient's first and last name:**

**Date of birth:**

**Gender:**

If the current prior agreement application directly related to an accident?  Yes  No

If so, please also attach a detailed report describing the circumstances of the accident.

### To be completed by the attending practitioner

---

**Proposed place of hospitalization (name of institution, address, telephone, fax, e-mail):**

**Attending physician's information (name, address, telephone, fax):**

**Reason for the hospitalization/clinical symptoms presented/precise medical diagnosis:**

**Please provide the ICD-Code:**

**How long has the patient been experiencing the symptoms prior to consulting you?**

**When did the patient first consult any doctor for this condition? (mm/dd/yyyy)**

**When did the patient have been diagnosed with this condition? (mm/dd/yyyy)**

**Nature of the proposed operation and treatment program:**

**Length of stay (in days):**

**Date of admission:**

**Is this an extension?**  Yes  No

**Detailed estimated cost of hospitalization:**

**Physician's seal and signature:**

**Patient's signature:**

**Date:**

**For a medical information: +33 1 55 62 53 42**

I hereby authorize my Physician to send all the medical information required for deciding on my file to Henner's medical advisor.

*1/ The member's physician is authorized to send the Henner medical advisor all the medical information required for making a decision on the member's file.  
2/ The information will remain confidential. It will only be disclosed to the persons involved in your treatment.*