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PRE-CERTIFICATION FORM

All details in this form are to be duly completed and signed by the doctor, HR of the company and the insured member.

** Please note to complete the form.

Please submit this form at least 7 working days prior to the patient's surgery or procedure, together with any full medical report(s) and all available laboratory test result(s) held in respect of the patient to:

- Phone: 6715 9422
- Email: claims@ihp.com.sg

PARTICULARS OF INSURED MEMBER

Insured Name: _____ NRIC/FIN No.: _____

Claimant Name: _____ NRIC/FIN No.: _____ Relationship: _

Company Name: _____ Policy No.: _____ Contact No.: _

Mailing address: _____ Postal Code: _____

Bank Account Information for Electronic Transfer		
Name of Bank:	Bank Code:	Branch Code:
Bank Account No.:	Name of Bank Account Holder:	

I agree to hold Liberty Insurance Pte Ltd harmless and that it is fully and finally discharged of its obligations once it has made payment to the bank and bank account number given above.





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PRE-CERTIFICATION FORM

INDEMNITY OF PAYMENT

This section is required to be signed off:

Liberty Insurance Pte Ltd (herein referred to as “the Company”) hereby agrees to issue Letters of Guarantee to the Insured on the following terms and conditions:

- The Letters of Guarantee shall be used only for hospital admission by members insured under the abovementioned policy.
- For medical costs which are in excess of the limits of benefits and/or which are not reimbursable under the contract of insurance, the Insured shall undertake to repay the Company within 30 days from the receipt of all expenses that are not claimable under the policy. An interest charge of 6% will be levied on any amounts outstanding after 30 days.
- The Insured undertakes to furnish the Company details of the insured event for which the claim is made. Failure to furnish proof of claim will render the Insured responsible for all interest charges, if any, imposed by the Hospital for delayed settlement of hospital bills.
- The Insured agrees to return all unused Letters of Guarantee to the Company when the Insured terminates the contract of insurance with the Company or after the expiry of the validity period.
- The Insured agrees to inform all insured members to sign the Medisave Authorisation Form and Medishield Authorisation Form at the Admission Room of the hospital notwithstanding the production of the Letter of Guarantee.
- The Insured will be responsible on behalf of it’s subsidiary companies who are covered under the insurance policy for all the above-mentioned terms.
- The Insured will be responsible for any outstanding amount due to the Company in the event it is not recoverable from the employee due to the resignation of the said employee.

 HR Authorised Signature/Company Stamp
 Designation:

 Date:

 Individual Policyholder Signature

 Date:





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PRE-CERTIFICATION FORM

DECLARATION OF INSURED MEMBER

1. Is your condition / injury arising from workplace or during course of work? No Yes
2. Are you claiming from Work Injury Compensation Insurance for this surgery / admission? No Yes
3. Are you claiming from another insurer in respect of this illness/injury? No Yes
If Yes, please state:

Name of Insurance Company:

Policy No.:

CONSENT & AUTHORISATION OF INSURED MEMBER

1. I hereby authorise, agree and consent to:
- Liberty Insurance and Integrated Health Plans 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 dependents at any time and authorise the prior mentioned organisations to disclose all such information to Liberty Insurance and Integrated Health Plans.
 - Liberty Insurance and Integrated Health Plans collecting, using, and/or disclosing my personal data for the processing of pre-certification and such other purposes ancillary or related to the administering of my insurance coverage and claims adjudication.
2. I agree that Liberty Insurance and Integrated Health Plans 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.
3. 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 Liberty Insurance, Integrated Health Plans and my Employer.
4. I agree that a photocopy of this authorisation shall be considered as effective and valid as the original.

Insured Member's Signature: _____

Date: _



CONSENT & AUTHORISATION OF INSURED MEMBER

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: _____ Estimated Length of Stay: _____

3. Condition Requiring Treatment

Symptoms: _____ Symptoms Apparent from: _____
 Diagnosis: _____ Diagnosis Date: _____

ICD 10 Code: _____ Date when insured first had symptoms: _____

- a) Has this or any similar condition existed previously?
 If yes, please attach details and proceed to next question No Yes
- b) Has the patient had any prior treatment for this condition?
 If yes, please state date of treatment, name and address of doctor who treated the patient No Yes
-
- c) Please advise if the procedure is medically necessary. No Yes
- d) What will be the consequences if condition is left untreated? No Yes

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

- | | |
|---|--|
| <p>a) Hereditary or Congenital in nature <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>b) Genetic or chromosomal disorder <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>c) Psychological/Mental Condition <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>d) Self-inflicted injury <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>e) Attempted suicide <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>f) Sexually transmitted disease <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>g) Related to cosmetic treatment <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>h) Infertility related <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>i) Pregnancy related <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>j) Drug/Alcohol related <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>k) Heart Attack <input type="checkbox"/> No <input type="checkbox"/> Yes</p> | <p>l) Coronary Artery Disease <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>m) Heart Valve or Aorta Surgery <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>n) High Cholesterol <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>o) Hypertension <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>p) Stroke <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>q) Renal Failure
 <small>(any condition which requires kidney dialysis)</small> <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>r) Cancer
 <small>(including pre-cancerous Stage 0 Cancer)</small> <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>s) Diabetes
 <small>(Type 1 and Type 2 Diabetes)</small> <input type="checkbox"/> No <input type="checkbox"/> Yes</p> |
|---|--|



TO BE COMPLETED BY ATTENDING DOCTOR/PHYSICIAN

5. Is patient's condition/injury is due to an accidental event; please advise whether it is work-related? No Yes

6. Admit as: In-Patient Day Surgery

7. Is the patient currently taking any medication? No Yes
If yes, please indicate the medication below:

8. Cost Estimation

(A) Surgeon's Fee: SGD _____

(D) Room & Board: SGD ____/day X ____ = _____

(B) Anaesthetist's Fee: SGD _____

(E) Ward Class: ____

(C) Doctor's Attendance Fee: SGD _____

(F) Hospital Charges: (approx.):

Total Estimated Bill (A + B + C + D + F): SGD _____

Doctor/Surgeon's Signature: _____

Date: _

