Liberty Insurance

Pre-authorization Form

www.libertyinsurance.com.sg

Medical Claims Guide

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

Particulars of Claimant

Name of Insured:	**Policy No.:**
Name of Claimant:	**NRIC/FIN No.:**
Occupation:	**Contact No.:**

Declaration of Claimant

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

Consent and Authorization of Claimant

1. I hereby authorize, agree and consent to:
   a) Liberty Insurance to request from any hospital, physician, person or organization, all information with respect to any illness, injury, medical history, and copies of all hospital or medical records concerning myself or dependents at anytime and authorize the prior mentioned organizations to disclose all such information to Liberty Insurance.
   b) Liberty Insurance collecting, using, and/or disclosing my personal data for the processing of pre-authorization and such other purposes ancillary or related to the administering of my insurance coverage and claims adjudication.

2. I agree that Liberty Insurance 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, and my Employer.

4. I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

Date

Insured Member's Signature

To be completed by Attending Doctor/Surgeon:

Particulars of Attending Doctor/Surgeon

Name of Doctor/Surgeon:	**Name of Referring Doctor:**	**Name of Clinic:**
_____	_____	_____
Clinic Address: _____		Postal Code ( )

Details of Surgery/Procedure

Name of Hospital:	**Date of Admission :**	**Date of Surgery:**
_____	_____	_____
Surgical Code:	**Surgical Procedure:**	**Estimated Length of Stay:**
_____	_____	_____

Condition Requiring Treatment

Symptoms:	**Symptoms Apparent From:**	**Diagnosis:**
_____	_____	_____
Date of Diagnosis:	**ICD 10 Code:**	**Date when insured first had symptoms:**
_____	_____	_____

Has this or any similar condition existed previously? If Yes, please attach details and proceed onto next question.	☐ Yes	☐ No
Has the patient had any prior treatment for this condition? If Yes, please state date of treatment, name and address of the doctor who treated the patient: _____	☐ Yes	☐ No
Please advise if the procedure is medically necessary.	☐ Yes	☐ No
What will be the consequences if condition is left untreated? _____		
Is the condition of patient due to or related to:		
Hereditary or Congenital in nature	☐ Yes	☐ No
Genetic or chromosomal disorder	☐ Yes	☐ No
Psychological or Mental condition	☐ Yes	☐ No
Self-inflicted injury	☐ Yes	☐ No
Attempted Suicide	☐ Yes	☐ No
Sexually transmitted disease	☐ Yes	☐ No
Related to cosmetic treatment	☐ Yes	☐ No
Infertility related	☐ Yes	☐ No
Pregnancy related	☐ Yes	☐ No
Drug/Alcohol related	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No

Condition Requiring Treatment

Coronary Artery Disease	☐ Yes	☐ No
Heart Valve or Aorta Surgery	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Renal Failure (any condition which requires kidney dialysis)	☐ Yes	☐ No
Cancer (including pre-cancerous stage 0 cancer)	☐ Yes	☐ No
Diabetes (Type 1 and Type 2 Diabetes)	☐ Yes	☐ No
Is patient's condition/injury due to a work-related accidental event?	☐ Yes	☐ No
Admit as:	☐ Day-surgery	☐ Inpatient
Is the patient currently taking any medication? If Yes, please indicate the medication below: _____	☐ Yes	☐ No

Cost Estimation

A. Surgeon's Fee:	B. Anesthetist's Fee:	C. Doctor's Attendance Fee:
S$_____	S$_____	S$_____/visit X _____=_____
D. Room and Board:	E. Ward Class:	F. Hospital Charges:
S$_____/day X _____ = _____	_____	_____

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

S$_____

_____ Date

_____ Doctor/Surgeon's Signature