



PRE-CERTIFICATION MEDICAL FORM

PROVIDER INFORMATION			
To:	Singapore Life Ltd.	Tel:	(65) 6715 9423
	C/O Integrated Health Plans (IHP)	Fax:	(65) 6715 9428

PATIENT INFORMATION	
Name of Insured:	Policy Number:
NRIC / FIN No:	Contact No:
Date of Birth:	

TO BE COMPLETED BY DOCTOR	
Admission Date :	Diagnosis :
Admitting Hospital :	Surgical Code:
Name of Treating Doctor :	Operation Code:
Tel No :	
Fax No :	
Email Address :	
Admit As :	<input type="radio"/> For Day Surgery <input type="radio"/> Hospitalisation with Surgery <input type="radio"/> Hospitalisation without Surgery
Nature of Surgery :	
Date of Illness/accident first begin (dd/mm/yy) :	

COST ESTIMATED (TO BE COMPLETED BY HOSPITAL)	
Surgeon Fee : SGD	Other Fee : SGD
Hospital Charges (approx) : SGD	<i>Pls provide the breakdown:</i>
Anesthetist Fee : SGD	

Please fax the completed form to 6715 9428 or email to enquiry@ihp.com.sg