# CONFIDENTIAL MEDICAL DECLARATION FOR ALL HOSPITALISATION PRIOR APPOVAL REQUESTS

To be completed by the doctor or hospital service in charge of your medical follow-up

**In case of emergency, please contact our HOSPITALISATION SERVICE**
by phone: 01 73 02 93 99 **OR** by e-mail: hospitalisation.expat@april-international.com

In order for our Medical Examiners Team to be able to decide on your hospitalisation prior approval request **your doctor must fill in the requested information and you must send us this form together with the additional documents indicated in the box below**. On receipt of your **COMPLETED request**, it will be examined by our Medical Examiners Team, who will communicate the response within **72 hours**. Our Medical Examiners Team has the right to request any additional medical information deemed necessary to review your request.

**Please send your documents to the attention of the Medical Examiner:**

* by e-mail to: hospitalisation.expat@april-international.com
* via your EASY CLAIM application
* or by post marking your envelope as « confidential » to the following address::
APRIL International Care France / Mail Service
For the attention of the Medical Adviser
1, rue du Mont -CS 80010 - 81700 BLAN -France

## What documents should you enclose with your request?

**Please send us:**
* This confidential medical declaration completed and signed by your doctor..
* The situation report and **in case of emergency admission**, the emergency room report.
* Medical report explaining the medical necessity of the hospitalization or surgery.
* Examination report (consultation, imaging, biopsy, etc.) in relation to the planned hospitalisation or intervention.
* The detailed cost estimate (accommodation costs, practitioner's fees, etc.).
* **In case of an accident,** please complete your request with the accident report, detailing the circumstances of the accident.

## Information about the care recipient

| Surname and first name: | | E-mail: |
|---|---|---|
| Date of birth (DD/MM/YYYY): | Sex: | Family relationship: |

## Information about the principal insured

| Surname and first name: | Date of birth (*DD/MM/YYYY*): |
|---|---|
| Name of your policy: | Client reference number: |
| E-mail: | Telephone: |

## To be completed by the hospital / the doctor

| Name of the hospital: | |
|---|---|
| Address: | |
| Telephone: | E-mail of the admissions service: |
| Name of the Doctor in charge of treatment: | |
| Address: | |
| Telephone: | E-mail: |


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## Reason for hospitalisation, to be completed by the doctor in charge of your follow-up

Please fill in the following necessary information for the hospitalisation prior approval of the patient named above.

Reason for hospitalisation: ◯ Medical ◯ Surgery ◯ Delivery ◯ Spa treatment ◯ Other

| Length of stay: | Admission date (*DD/MM/YYYY*): | Discharge date (*DD/MM/YYYY*): |
|---|---|---|
| Estimated cost of hospitalisation: | Hospital fees: | Practitioner's fees: |

| | | | |
|---|---|---|---|
| 1 | How long have you been in charge of the patient (date of first consultation, *DD/MM/YYYY*)?: | | |
| 2 | Is the hospitalisation due to delivery? | ◯ YES ◯ NO | Is it a caesarean section? ◯ YES ◯ NO |
| 3 | **a)** Is it due to an accident?: ◯ YES ◯ NO An illness?: ◯ YES ◯ NO | | |
| | **b)** What is the patient's condition (diagnosis and stage)?: | | |
| | **c)** What is the cause of the condition? What are the circumstances of the accident? | | |
| | **d)** Date(s) of first symptoms (*DD/MM/YYYY*): | | |
| | **e)** Date of diagnosis (*DD/MM/YYYY*): | | |
| 4 | **a)** Is it a recurrence of a previous condition? ◯ YES ◯ NO | | |
| | **b)** Date of the first episode (*DD/MM/YYYY*): | | **c)** Date of first consultation (*DD/MM/YYYY*): |
| | **d)** Nature of symptoms and previous treatments: | | |
| 5 | Are there any pre-existing or aggravating conditions? | ◯ YES ◯ NO | If **YES**, which ones and what is the date of diagnosis (*DD/MM/YYYY*)? |
| 6 | Is there a prescribed treatment and/or care plan in progress or scheduled? | ◯ YES ◯ NO | Please attach dated prescription(s), indicate treatments and start date: |
| 7 | Is the treatment prescribed for this condition urgent? | ◯ YES ◯ NO | If **YES**, how soon? |

**This certificate is provided at the request of the person concerned for all legal intents and purposes**

**Doctor's stamp and signature:**

Date:

**Patient's signature:**

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