HERITAGE HEALTH

We care about your health

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A. Pre Authorisation Request

	Membership Number
Principal Member Details Below	
Surname	
First Names	
Personal Postal Address	
Tel Code and Number	
Fax Code and Number	
Cell Phone Number	
Email Address	
Date of Birth	D D M M Y Y Y Y
Gender	Male Female
ID/Passport Number	

B. Of Patient requiring Pre-Authorisation

Full Names of Patient	
Tel Code and Number	
Fax Code and Number	
Cell Phone Number	
Email Address	
Date of Birth	D D M M Y Y Y Y

I AUTHROISE THE MEDICAL PRACTITIONER TO OBTAIN THE PRE AUTHROISATION-ON MY BEHALF

…… ……

SIGNATURE PRINCIPAL MEMBER/PATIENT DATE

C. Of Attending Medical Practitioner

Information on this page to be provided by the doctor.

Name of Doctor

Name of Practice

Practice Number

Tel Code and Number

Fax Code and Number

Mobile Number

Email Address

D. For the Pre-Authorisation

Primary Procedure

Primary Diagnosis

Admission Date

Name of Hospital

Medical History

Risk Factors

Any Previous Admissions and reasons

……. ……

SIGNATURE OF DOCTOR/PRACTICE DATE

E. Authorisation details *(office use)*

Date received: …….

Date processed: …….

Approved: ……

Authorisation number: …….

Declined and reason: …….

Inform hospital: …….

Inform doctor: ……

Inform patient: …….

Employee name: …… Signature: …… Date: ……