LIBERTY

In it with you

Liberty Health Cover Hospital and Scan Pre-authorisation Form

Important: please read the following before completing this application form

- Please write clearly using capital and block letters.
- It is compulsory to complete all the fields in this form.
- Please submit your completed forms and documents required and email to preauthmoz@libertyhealth.net

1. PERSONAL DETAILS | PRINCIPAL MEMBER OR POLICYHOLDER

Please complete in block capitals

First name and last name

Title | Membership or policy number

2. GENERAL PATIENT INFORMATION

Please complete in block capitals

Patient's first name and last name

Title | Date of birth (Y Y Y Y M M D D) | Gender M F

3. DOCTOR AND PROVIDER DETAILS

Please complete in block capitals

Hospital name

Hospital Practice No./Liberty Provider No.

Treating doctor's first name and last name

Practice/Registration/OMM No. | Speciality

Work number (include country and area code) +

Mobile (include country and area code) +

E-mail

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

ADMISSION DETAILS

Please complete in block capitals

Date of admission (Y Y Y Y M M D D) | Time of admission : AM PM

Ward Type

General | Surgical | Maternity | Paediatric | Isolation | Day ward | Psych | ICU

Date of discharge (Y Y Y Y M M D D)

Initial diagnosis & ICD-10 code

Discharge diagnosis & ICD-10 code

Description of procedure/operation

Tariff code | CPT code | Emergency admission Y N

TREATMENT PLAN (MEDICAL/SURGICAL AND ASSOCIATED/ALLIED TREATMENT INCLUDING MEDICATION AND DOSAGE)

RADIOLOGY REQUEST

Scan type requested

Radiology practice name and number

Referring doctor's name

Referring doctor's speciality

Please provide motivation/reason

ACKNOWLEDGEMENT BY EXAMINING DOCTOR

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

Having conducted a personal medical examination, I certify that the particulars are, to the best of my knowledge and belief, true and accurate.

I acknowledge that the Insurer will rely on such particulars when making any recommendations regarding the payment of treatment and services.

Doctor's last name

Doctor's first name(s)

Doctor's signature

Date Y Y Y Y M M D D

PATIENT'S DECLARATION

I am aware that the Insurer may request relevant medical information from any medical facility, laboratory, clinic, hospital, doctor or specialist that it requires to make an appropriate funding decision about my care.

In order for the Insurer to fully assess this application for benefits, I hereby give my consent for them to obtain this information from the relevant healthcare provider. I further understand that this application is subject to the Liberty Health Cover Policy Conditions, available benefits and relevant funding protocols.

Patient's signature

Date Y Y Y Y M M D D