Request for eligibility of treatment

Patient's details:

Full name: _____

Date of birth: _____

Insurance number: _____

Provider details:

Hospital name: _____ Country: _____

Name of specialist in charge: _____

Name of contact point for enquiries: _____ Email: _____

Fax number: _____ Tele number: _____

Medical information:

Symptoms: _____ Diagnosis: _____

_____ _____

_____ _____

Vital signs: BP_____ Pulse_____ Temp_____ RRate_____

ICD code: _____

Date when symptoms for this condition were first noticed by patient: _____

_____

When was this condition first diagnosed? _____

Treatment details: _____

_____

Details of patient's regular medication: _____

_____

Previous related treatment history: _____

_____

Date of admission: _____

Expected date of discharge: _____

Estimated hospital charges: _____ Estimated physician charges: _____

Signed: _____ Position: _____

Please ensure this information is provided 24 hours prior to admission.
Failure to complete this information in full could delay our ability to provide a decision.

Return this document to the following:
Email: pre-authorisation@bupa-intl.com or fax: 0044 1273 866301