PRE-APPROVAL REQUEST FORM

AlKoot INSURANCE & REINSURANCE الكوت للتأمين و إعادة التأمين

PROVIDER DETAILS

Provider Name:

Provider License No.: Provider Location:

Contact No.: Fax No.:

PATIENT DETAILS *(To be filled by Patient)*

Patient Name:

Al Koot ID No.: Qatar ID:

Date of Birth: ☐☐ ☐☐ ☐☐☐☐ Gender: ☐ Male ☐ Female

Email ID: Contact No.:

Policy Holder Name:

Company Name: Employee:

HOSPITALIZATION DETAILS *(To be filled by Provider)*

Date of Admission: ☐☐ ☐☐ ☐☐☐☐ Date of Discharge: ☐☐ ☐☐ ☐☐☐☐

Name of Treating Doctor: License No.:

Details of Presenting Complaints:

_____

_____

Duration of Present Ailment: _____ days

Past History relevant to Present Illness (if any):

_____

_____

Duration of Above Illness: _____ days

Benefit Type: ☐ OP ☐ IP ☐ Day Care ☐ Maternity ☐ Dental ☐ Optical

Encounter Type: ☐ With Emergency ☐ Without Emergency

Treatment Type: ☐ Emergency ☐ Elective Date of first Consultation: ☐☐ ☐☐ ☐☐☐☐

Provisional Diagnosis: _____ ICD Code:_____

Out-Patient Treatment details:

_____ Code _____

_____ Code _____

In-Patient Treatment details:

_____ Code _____

_____ Code _____

Particulars	Charges	Particulars	Charges
Room Charges (_____QAR X _____ days		Investigations	
Consultation / Surgeon Charges		Pharmacy	
OT Charges		Laboratory	
Consumables		Package (If applicable)	
Anesthesia		Others	
Total expected cost of hospitalization			

DECLARATION:

I/We hereby declare that the information furnished in this PreApproval request form is true & correct to the best of our knowledge. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim shall be forfeited.

Patient's Signature with Date: Treating Doctor Signature with Stamp: