MEDICAL ADMINISTRATOR
KENYA LIMITED

PRE-AUTHORISATION FORM

Hospital: ..... Date of Admission: .....

Company: .....

Employee's Name: ..... Staff No: .....

Patient's Name: ..... Date of Birth: .....

Reg. No. /Invoice No. : .....

When was the Condition:

First Diagnosed: ..... Last Treated: .....

Causes of illness/s? : .....

.....

Any Underlying Condition: .....

Is condition likely to Recur : .....

Is Condition Congenital : .....

Has the patient been tested for HIV?

(If so give the results): .....

Clinical Summary: .....

.....

Nature of Treatment given & Recommendations (if maternity, please indicate if this is was an emergency cesarean section)

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Estimated Cost of Treatment

1. Hospital Fees: .....
2. Doctor's Fees: .....

Estimated Hospitalization Duration: .....

Doctor's Name: .....

Date: ..... Doctor's Signature & Stamp: .....

Claimant's Certificate: (Parent to sign if patient is a minor)

I consent to my Insurance Brokers/ Insurers seeking information from any doctor I or my dependents have consulted and to receive extracts from such consultation and/ or treatment.

Signed: ..... Date: .....