NHIF 8d/09
Revised 2020

Pre-auth Request No._____ **L.O.U Number:** _____

DENTAL SERVICES PRE-AUTHORIZATION FORM

PLEASE BE AS COMPREHENSIVE AND ACCURATE AS POSSIBLE WHEN COMPLETING THIS FORM. ERRORS OR OMMISSIONS MAY DELAY AUTHORIZATION

SECTION 1: PATIENT INFORMATION *(To be filled by the Patient/Guardian)*		
Surname: Other Names:		County:
NHIF Member No:	Patient's ID No/Birth Cert./ Notification No:	Patient's Phone No*:
Relationship to Principal Member: Self: ☐ Spouse:☐ Child: ☐		Principal Member Phone No:
If patient is below 18 years, Name of Guardian:		Relationship to patient:
Do you have any other MEDICAL insurance cover? Yes ☐ No ☐		If YES, give details:

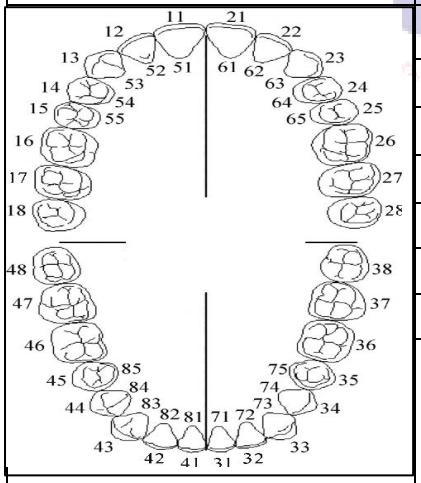
PATIENT OR AUTHORISED PERSON'S DECLARATION: I certify that the above information is correct and give specific consent for selected procedures to be done. I understand that it is an offence to knowingly make any false statement for purposes of obtaining any benefit under NHIF Act.

Signature: _____ **Date:** _____

SECTION 2: TREATMENT DETAILS

Facility Name: Facility Code:

Dental Practitioner's Name: KMPBD No./License No.:



Please tick tooth No. to be treated	**Service Date**	**Procedure Code**	**Description of Service**	**Tooth No:**	**Cost**
	Total Amount				

For Services that require revisits, indicate the appointment dates in the fields below

Procedure	**Procedure**
_____	_____
1st Visit _____	1st Visit _____
2nd Visit _____	2nd Visit _____
3rd Visit _____	3rd Visit _____
4th Visit _____	4th Visit _____

PRACTITIONER DECLARATION: This is to certify that to the best of my knowledge, the information contained above, and any attachments provided is true, accurate, and complete and the requested service(s) is necessary to the health of the patient. I understand that it is an offence to knowingly make any false statement for purposes of obtaining any benefit under NHIF Act.

Facility stamp

Signature: _____**Date:** _____

Notice: Any person/institution who/which knowingly files a statement of request or claim containing any misrepresentation or false, incomplete, or misleading information may be guilty of medical fraud punishable under law or as per the statutes of NHIF operation.

- All fields in this form are mandatory and **MUST** be completed to inform pre-authorization decision.
- Turnaround for prior-authorization response is **up to 48 hours once all relevant** information has been received.
- **Consultation** for dental services will be paid once annually for all beneficiaries with the authorized first visit.
- **Emergency pain management and infection control procedures** may not await a prior authorization approval. The practitioner shall submit a medical justification of the procedure done to accompany the request for approval following treatment. The Fund shall not be financially liable for services that have not been preauthorized.
- Procedure codes are as outlined in the claims processing manual and in the Hospital web application.
- The providers shall be responsible for ascertaining beneficiary's eligibility to utilize the procedure and treatment.
- Payment for services rendered is subject to verification of outcomes of care and beneficiary eligibility as at the date of service provision. Contractual obligations with the provider take precedence.
- Medical co-insurance declaration is **Mandatory**, failure to which approval will be withheld or monies recovered in case of falsification to obtain benefits.
- **PATIENT OR AUTHORISED PERSON'S DECLARATION:** This declaration provides that the Principal member and beneficiary details are accurate and complete as per the form, that the medical information and treatment plan herein is accurate and can be utilized for medical insurance purposes.
- **HOSPITAL DECLARATION:** This declaration provides that the hospital is declared and contracted, and is operational under the provisions on location, hospital code and contracted services. It also provides that the member/beneficiary is eligible for access to the contracted benefits as per the clauses on "OBLIGATIONS OF THE HEALTH FACILITY", and the terms of engagement. It also provides that the hospital has taken due diligence to identify the beneficiary and provided necessary details on the eligible benefits and financial liability.
- **PRACTITIONER DECLARATION:** The listed beneficiary has presented for clinical management and that the practitioner is duly qualified and registered by the relevant authority in Kenya.