



Pre-certification Medical Form

To: Fax No: Tel No: Date:	From: Aetna Global Benefits (Americas) Limited Fax No: +1-860-262-9111 Tel No: +1 877 248 2197 Pages: 2
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Insured: Policy No Location:	Date of Birth: Claim No: Contact No:
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To be completed by treating physician

Treating Physician: Tel No: Fax No: E-mail:	Referring Doctor: Tel No: Fax No: E-mail:
Admitting Hospital / Medical Facility: Tel No: Fax No:	Admission Date: Discharge Date: Contact Person:

To be completed by treating physician

Condition requiring Treatment: _____ <small>Please advise if a chronic condition</small>	
Underlying Cause: _____	
First Consultation date ___/___/___	Symptoms apparent from ___/___/___
Has this or any similar condition existed previously? <input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes please attach details)	
Proposed Treatment/Procedure _____	
Medication currently taken _____	
Admit as:	In-patient / Day patient / Out-patient
Proposed admission date: ___/___/___	Estimated length of stay: _____
Class of Room:	Private / Semi-private / Ward



Cost Estimate (to be completed by all relevant parties)

Surgeons fee (approx)	_____	Anaesthetist Fee(approx)	_____
Room Rate	_____	Hospital Charges(approx)	_____
Agreed Fee	_____	Prompt Payment Discount	_____
Package Cost	_____		

Signature Doctor / Hospital Authority _____ **Date** __/__/_____

Please return by e-mail to AetnaInternationalAmericasPrecert@Aetna.com