

**Pre-certification Medical Form**

To: Limited Fax No: Tel No:	From: Goodhealth Worldwide (Asia Pacific)  Fax No: Tel No:
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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:    _____

**Cost Estimate (to be completed by all relevant parties)**

Surgeons fee _____	Ward Round Fee _____	per day	Anaesthetists Fee _____
Room Rate _____	Class of Room _____		
Package Cost _____	Other Fee _____		
Hospital Charges (approx.) _____	Prompt Payment Discount _____		

**Signature Doctor / Hospital Authority** \_\_\_\_\_ **Date** \_\_/\_\_/\_\_

Please return by fax to +852 2866 2555 (Office Hour) / +852 2528 9933 (Non-office Hour) or e-mail to [asiapacservices@aetna.com](mailto:asiapacservices@aetna.com) along with full medical reports held in respect of the patient and any laboratory test results.