



Pre-certification Medical Form

To: Aetna International	From:
Fax No:	Fax No:
Tel No: 852 3071 5022	Tel No:
Date:	Pages: 1 of

Insured:	Date of Birth:
Policy No:	Claim No:
Location:	Contact No:

To be completed by treating physician

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

To be completed by treating physician

Condition requiring Treatment(Please advise if a chronic condition): _____

Underlying Cause: _____

First Consultation date: __/__/__ Symptoms apparent from __/__/__

Has this or any similar condition existed previously? No 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 Estimated (to be completed by all relevant parties)

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

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

Please return this form along with full medical reports/ any laboratory test results held in respect of the patient.

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