Pre-certification Medical Form

To:	From: Aetna Global Benefits (Europe) Limited
Fax No:	
Tel No:	
Date:	Pages: 2

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 / Medical Facility:	Admission Date:
	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: _____

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 AIMedicalTeamEurope@Aetna.com