

预授权申请表

PRE-AUTHORIZATION REQUEST FORM

Contact telephone no.: 800-820-5102/021-61870220

E-Mail: medical@mshasia.com

A 病人信息 Patient Information (带*为必填项)	
*姓名 Name:	*客户号 Member#:
*出生日期 DoB: YY (年) ____ MM (月) ____ DD ____	*联系电话 Contact number:
*电邮 Email:	
B 医疗机构信息 Provider information (带*为必填项)	
*医疗机构全称 Full Name of Provider:	*主治医生 Attending Physician:
*医院详细地址 Address:	
就诊科室 Department of Visitation:	*电邮 Email:
联系电话 Contact number:	传真 Fax:
C 医疗信息 (由医生填写) About the treatment (filled by the doctor) (带*为必填项)	
就诊原因 treatment reason: <input type="checkbox"/> 疾病 Disease <input type="checkbox"/> 意外 Accident	
* 就诊类型 treatment type: <input type="checkbox"/> 门诊 OP <input type="checkbox"/> 住院 IP <input type="checkbox"/> 日间手术 Day case (预计术后观察时间 Estimated postoperative observation time ____ 小时 hours)	
* 医疗诊断 Medical Diagnosis:	
* 起病时间 Onset date:	
* 诊疗计划 (含手术方案) Therapeutic schedule (including surgical plan):	
* 入院/治疗日期 Admission/Treatment date 年 YY ____ 月 MM ____ 日 DD ____	预估住院天数 Estimated hospital stay
* 预估总费用 Estimated total cost: _____ 币种 Currency _____	
重要检查结果 (可附上具体报告结果代替) Physician examination result (examination report copy will work)	
注: 1. 请随此表附上病历和诊断报告以证明此申请的医学必要性。 Please attach any available medical records and diagnostic reports along with this form to support the medical necessity. 2. 请将所有相关的医学资料与填写完整的《预授权申请表》一同递交。 如果没有填写事先授权表或者重要信息缺失,可能给客户造成不必要的损失。 Please submit any supporting medical documentation along with this completed Pre-authorization Form. Failure to complete and submit this form could result in substantial penalties for the client.	