PRE-AUTHORIZATION INFORMATION FORM

Mandatory for Non-Emergency Hospitalization

Pak-Qatar Family Takaful Limited

For Benefit & Eligibility inquiry: (021) 4380357- 61

Pak-Qatar's Fax No.: (021) 4386451

Fax Date:

Attention:

Part A

☑ *To be completed by the covered **Individual Member** only.*
☑ *Do not leave any blank, unanswered questions, dates or signatures, wherever applicable.*

Patient's Takaful Certificate Number:	***Patient's Sex:*** ☐ *Male* ☐ *Female*
Patient's Name:	***Age:***
Date of Birth: ☐☐/☐☐/☐☐☐☐	***CNIC Number:*** ☐☐☐☐☐-☐☐☐☐☐☐☐-☐
Residence Address:	☎ ***Mobile:***
Scheme Number:	***Participant (Employer) Name:***
Employee Name:	***Relationship with patient:***

Part B

☑ *To be completed by the **Treating Physician** only.*
☑ *Do not leave any blank, unanswered questions, dates or signatures, wherever applicable.*

Name of Treating Physician:

Hospital Name *(where treatment required)**:***

Symptoms:

On what date did the symptoms first occur: ☐☐/☐☐/☐☐☐☐

Principal Diagnosis:

Associated Diagnosis:

Has the patient previously consulted any doctor for the above-mentioned medical condition? ☐ *Yes* ☐ *No*

If "Yes", for each doctor and hospital consulted, state name and address, treatment provided.

Name of Doctor/Hospital	*Date of Consultation*	*Reason for Consultation*	*Treatment/Results*

Procedure/Operation/Treatment advised:

Verification by Treating Physician: *I/We hereby certify that all answers to questions appearing above are true and complete to the best of my/our knowledge and belief.*

Date of Statement: ☐☐/☐☐/☐☐☐☐

Signature of physician

Part C

Expected Date of Admission: ☐☐/☐☐/☐☐☐☐

Expected Duration of Hospitalization:

Expected cost of Hospitalization

Expected break-up of items	**Expected Amount** (in Pak Rupees)
Room & Board	
Physician Visit Fee	
Cost of Procedure/Operation	
Surgeon Fee	
Anesthesia Fee	
Laboratory	
Medicines	
Others	

DECLARATION & AUTHORIZATION

I hereby certify that all answers to questions appearing on this form and documents submitted with this form are true and complete to the best of my knowledge and belief.

*I, the above claimant, hereby authorize any doctor , hospital,, clinic, or medical service provider, takaful/insurance company, or any other institution, or any person, who has any information or record about me and/or any of my dependents to provide **Pak-Qatar Family Takaful Limited** with the complete information including copies of their records with reference to any sickness, accident, disability, any treatment, examination, medical investigation, advice of healthcare provider,. Photocopy of this authorization shall be valid as the original.*

Signature of claimant Individual Member

Employee will complete and sign this form on behalf of minor children

Date of Statement: ☐☐/☐☐/☐☐☐☐

If you have any questions regarding pre-authorizations, contact our Customer Benefit Services Department: at (021) 4380357-61, 4386452.