aetna

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.
Fax: +852 2866 2555 Email: PAA@talent-trust.com