Pre-certification Medical Form

To:	From: Aetna Global Benefits
Fax No:	Fax No: 00971 4 324 3550
Tel No:	Tel No: 00971 4 324 0040
Date:	Pages: 1

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:
Tel No:	Discharge Date:
Fax No:	Contact Person:

To be completed by treating physician

Condition requiring Treatment: _____
Please advice 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 Estimate (to be completed by all relevant parties)

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

Please return this form along with full medical report/s any laboratory test results held in respect of the patient.
Fax: + 971 4 324 3550
Email: PAME@talent-trust.com