

AFI PRE-AUTHORIZATION FORM FOR HOSPITALIZATION FROM PANEL & NON-PANEL HOSPITALS

IMPORTANT INSUTRCTIONS FOR THE INSURED MEMBER:

- Please use this form when you are going to avail the hospitalization treatment from any panel or non-panel hospital.
- For prompt and efficient approval, please complete the Pre-Authorization Form accurately, and attach all supporting documents.
- If you have any difficulty in filling this form, please contact our Medical Department at the below numbers.

IMPORTANT INSUTRCTIONS FOR THE HOSPITAL / DOCTOR:

- Please ensure all columns are completely filled before faxing/emailing the form to Alfalah Insurance Company.
- Please take 3 days prior approval before admitting a patient for non-emergency procedures.
- Admission for investigations and work up is not covered under AFI policy.

| | |
|--|--|
| Policyholder's / Employer Name | |
| Policy Number | |
| Employee Name | |
| Employee ID | |
| Patient's Name and Age | |
| Hospital Name | |
| Hospital Address & Phone No. | |
| To be Admitted On (Date) | |
| Presenting Complaints | |
| History of Presenting illness (specify duration) | |
| Any Associated disease | |
| Final Diagnosis | |
| Procedure to be Undertaken | |
| Expected Length of Stay | |
| Expected Cost of the Treatment | |
| Attending Doctor's Name, Signature & Stamp | |

INFORMATION REGARDING HOSPITAL AND TREATING DOCTOR

For treatment from a non-panel hospital, please follow the following criteria for taking treatment from any hospital.

DEFINITION OF HOSPITAL

"Hospital/Nursing Home" means an establishment in Pakistan for indoor medical care and treatment of patients which is registered with the appropriate local authorities as such and benefits from the supervision of a Medical Practitioner on a 24 hour basis, and complies with at least the following criteria:

- it has at least 10 inpatient beds
- it has a fully equipped operating theatre where surgery is performed
- it employs qualified nursing staff on a 24 hour basis
- maintains daily records of patients

By the nature of the medical treatment provided is an establishment properly recognized as a Hospital/Nursing Home within the locality and fulfills all the demands ordinarily or customarily of a Hospital for medical treatment, and where all medical treatment is admin registered by a Medical Practitioner, and is not, except incidentally, a place of rest, a place for the aged, a place for drug-addicts or place for alcoholics, a hotel, health spa, massage center or any similar establishment.

Please provide following information about the hospital you want to take services from:

| | |
|---|---------|
| Hospital / Nursing Centre Name | |
| Hospital Address | |
| Is it a 24/7 services providing facility? | (Y / N) |
| Number of consultants available in hospital | |
| Number of medical officers available 24/7 | |
| Number of nurses & paramedical staff available 24/7 | |
| Number of rooms, | |
| Beds | |
| Wards | |
| ICU, | |
| NICU | |
| Is there any Pharmacy & Laboratory attached with Hospital | (Y / N) |
| Does the hospital maintain the daily record of patients? | (Y / N) |
| Does hospital maintain written billing records? | |
| Is there emergency room/ available? | |
| Contact numbers of Hospital & email | |

Please provide following information about the treating doctor/ physician:

| | |
|----------------------------|--|
| Doctor/ physician's name | |
| Qualifications/PMDC number | |
| Contact number & email | |

FOR ALFALAH INSURANCE USE ONLY:

| | |
|----------------------|----------------------------------|
| Date Received | _____ |
| Approved By | _____ Date Approved _____ |
| Remarks | _____ _____ |



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