

Pre-authorization Form (事先授权表)

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Note: Please submit any supporting medical documentation along with this completed Pre-authorization Form. (备注: 请将所有相关的医学资料与填写完整的事先授权表一起递交)

Provider Contact Name (联系人姓名): _____ Fax #(传真): _____
Phone #(电话): _____ E-mail(邮件地址): _____
Name of Facility(医院名称): _____
Address of Facility(医院地址): _____ Country(国家): _____
Name of Attending Physician(主治医生): _____

The following must be filled out by the provider of service(以下各项须由医生填写):

Name of Patient(病人姓名): _____
Date of Birth (出生日期): _____
Policy Number(保险号码): _____
Patient's Phone #(电话): _____

Caused by(导致原因):

Check One(选择其一): Accident (事故) _____ Illness(疾病) _____ Delivery (生育) _____

Date of Invasion at this time(本次发病时间): _____

Physical Exam Result(体格检查结果): _____

Lab Test Results(实验室检查结果): _____

Related Illness History(相关疾病过去史): _____

Medical Diagnosis(医疗诊断): _____

Failed Conservative Medical Management (经历的未成功的保守治疗方案): _____

Procedure(步骤):

Check One(选择其一):

Outpatient (门诊) _____

Expected Procedure(预计治疗 / 检查 / 门诊手术): _____

Expected Date of Procedure(预计日期): _____

Inpatient(住院) _____

Expected Procedure(预计治疗 / 检查 / 住院手术 / 生育): _____

Expected Length of Stay(预计住院总天数): _____

Date of Operation(手术日期): _____

Name of Operation(手术名称): _____

Days of Pre-operation(术前时间): _____ Days of Post-operation (术后时间): _____

Estimated Cost(估计费用): US\$ _____ / RMB _____

Method of Anesthesia(麻醉方式): _____

If Assistant Surgeon is needed, please provide notes explaining medical necessity(如还需别科(院)医生会诊, 联合手术, 请阐释医学必要性):

Additional Comments(备注):

Failure to complete and submit this form could result in substantial penalties for the client (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).