Aafiya
Managing your care process

PRE-AUTHORIZATION FORM

Provider Name :	CITICARE MEDICAL CENTER LLC	**Patient Name :**	PARDIP KAUR		
Insurance Company :	DUBAI NATIONAL INSURANCE & REINSURANCE CO. (P.S.C)	**Patient Mobile No :**		**File No :**	
Company name :	PACE BRITISH SCHOOL L L C	**Member ID :**	1474831		
Date Of Treatment :	24/02/2025	**Date Of Birth :**	18/09/1973	**Gender :**	FEMALE

Chief Complaints :

Referral (if needed) :

Clinical Findings : **BP :** **TEMP :** **HR :** **RR :**

Diagnosis :	**Diagnosis Code :**	**Date of Onset :** (dd/mm/yyyy)

PEC/CHRONIC ☐ **CONGENITAL** ☐ **MATERNITY** ☐ **DENTAL** ☐ **OPTICAL** ☐ **WORK RELATED OTHERS** ☐

Out Patient Investigations/Treatment required :

Laboratory :	**Radiology :**	**Others :**	**Medicine/IV Fluids :**

Estimted Cost :

Cost Breakdown For Inpatient Services :

Services	Total Amount
Room and Nursing Charges	
Procedure	
Consultation Fees	
Consumables	
Laboratory	
Radiology	
Pharmaceuticals	
Estimated Total Amount	

For Aafiya Use Only Approval Code :_____

In accordance to policy terms, conditions & exclusions :

Approved ☐ Partially Approved ☐ Rejected ☐ Pending ☐

No. of days :_____ Daycase :_____

Copay : _____% Ded :_____

Remarks :

Approval valid up to 7 days as from: _____

Approval Officer : Date :

MEDICAL PRACTITIONER DECLARATION:

I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : Stamp:

Signature : Date:

PATIENT'S DECLARATION:

I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history to Aafiya for purpose of determining insurance benefits.

Patient's signature{Parent if minor} : Date:

Aafiya Medical Billing Services reserve its right during the Agreement period with the service provider, survey and audit the service provider's operations with respect to its performance of services, the patient visit details and claims.