Pre-Authorization Request FORM

HOUGHTON STREET CONSULTING **E-Mail: medical@houghtonstreet.net**

PROVIDER INFORMATION	
Name of Facility:	Provider Contact Name:
Name of Attending Physician:	
Phone #:	Email:

PATIENT'S DETAILS	
Member #:	Name:
DOB: MM/ DD/ YY/	Gender:
Nationality:	ID/Passport Number:
Tel.:	Email:
Principal member's name:	Principal member's ID/passport number:
Employer (for group member only):	Ref. # (refer to membership card):
Address:	

MEDICAL CONDITION

***Note: Detailed medical record can serve as a substitute to this part.**

Medical Diagnosis:

Physical Exam Result:

Lab Test Results:

Related Illness History:

Failed Conservative Medical Management:

PROCEDURE	
Expected Date of Procedure:	Expected Length of Stay:
Expected Procedure: □ Outpatient Exam/Surgery □ Inpatient Treatment □ Delivery	 □ Special imaging (CT/MRI/PET) □ Physiotherapy □ Long-term medication
Name of Operation:	Date of Operation:
If Assistant Surgeon is needed, please provide notes explaining medical necessity:	
Estimated Cost:	

ADDITIONAL COMMENTS

Medical Practitioner's/Surgeon's Signature:

Date: MM/ DD/ YY/

Note: Please submit any supporting medical documentation along with this completed Pre-authorization Form. Failure to complete and submit this form could result in substantial penalties for the client