



GOOD HEALTH PLAN LTD.

Ph.No. 55825003 fax no. 55828081

REQUEST FOR PRE-AUTHORIZATION

Corporate name _____ Emp_code _____ GHPL ID.No. _____

Policy No. _____ Period : ___/___/___ to ___/___/___ Fresh/Renewed(F/R): _____

Patients Name _____ Age ___ Sex ___ Employee/Insured Name _____

NAME OF HOSPITAL..... Fax No

[To be filled by Treating Doctor]

Type of admission: **Planned / Emergency (for planned admissions GHPL Authorization is a pre-requisite for admitting the patient)**

Probable Date of admission (for elective/ planned admission) _____

Admission Date (for emergency cases) _____

Present Complaints with duration

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.....
.....

Past History.....

HTN / DM / ASTHMA / CAD If, yes since when

Provisional Diagnosis (In Capitals)

General Examination:
Investigations intended / if already done with findings:
Plan of Treatment (surgical / medical mgmt), In case of medical management, please provide details of prescribed medicines)

Possible Duration of stay: _____ Approx. total expenses _____

Name of the Doctor with Reg. No.: Signature :

- *Admissions for investigations / evaluation is not covered, GIC/underlying Insurance co. rules applicable*
- If space not sufficient, attach separate sheets.

GHPL AUTHORISATION LETTER

Doctor's Comment :

Amount Approved : _____

Signature of the Doctor