Pre-Authorisation Form

PLEASE MAIL COMPLETED FORM TO:
P.O. Box 31737, Lilongwe 3, Malawi
OR E-MAIL TO: info@medhealth.mw

Kang'ombe House, 1st Floor, East Wing, City Centre, Lilongwe, Malawi
TEL: +265 1771 978 | +265 1771 979

Pre-Authorisation No. ____________________

Patient's Name ____________________ Date of Birth ____________________

Main Member's Name ____________________ Membership Number ____________________

Hospital ____________________ Practice No. ____________________

Referring Dr. (Name) ____________________ Practice No. ____________________

Contact Details ____________________

Diagnosis	I CD 10	Reason for Hospitalisation/Procedure/Ct/MRI

Procedure	Code

Investigations Done	Results

Medical History	Treatment Plan

Estimated length of stay (if applicable) ____________________ Date of admission/examination ____________________

Doctor's Signature ____________________ Date ____________________

FOR OFFICIAL USE ONLY

	NAME	DATE	SIGNATURE
Authorised By			
Approved By			

Stamp