Return to:

Hospital Managed Care Department

PSEMAS

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PSEMAS

PRE-AUTHORISATION FORM FOR HOSPITALISATION

1. PARTICULARS OF PATIENT															
Surname											Initials	3 [\perp	\perp
First Name															
Postal Address															
Date of Birth D D M M Y Y Y Y Se.	x M F	Relatio	onshi	p to I	Princ	cipal	Mer	mbe	r						
Telephone No.		Fax No.													
Medical Aid Membership No.															
2. PARTICULARS OF PRINCIPAL MEMBER															
Surname											Initials	3	\Box	\perp	\perp
First Name															
Date of Birth															
3. PARTICULARS OF MEDICAL PRACTITIONER															
Surname											Initials	s [I	
Practice No.															
Telephone No.				Fa	ax N	o. [
4. PARTICULARS OF HOSPITAL															
Name											Initials	3		\perp	
Practice No.				Conf	tact I	Pers	on _								
Telephone No.				Fa	ax N	o. [\prod	
5. PATIENT DETAILS															
Medical diagnosis	sis Comorbidities														
Planned Procedure															
Admission Date D M M Y Y Y Adm	nission Time			Esti	mate	ed Da	ays .			_ E	Estimated	d Co	ost _		
6. REGISTRATION (FOR OFFICIAL USE ONLY)															
Confirmation No.	Date D	D M	M	Υ	Υ	Y	/	٦	Time						
Signature		_													
Comments															