MEDICARE

ZENITH MEDICARE LIMITED

PRE-AUTHORIZATION FORM

DATE:_____ TIME:_____

NAME OF INSURED:_____ ID NO:_____

AGE: ☐ SEX: ☐ PHONE: ☐☐☐☐☐☐☐☐☐☐☐

PROVIDER NAME:_____

PROVIDER ID: _____

ADDRESS:_____

PRE-AUTHORIZATION REQUESTED: Hospitalization ☐ Surgery ☐ Investigation ☐ Others ☐

PROVISIONAL DIAGNOSIS:_____

INDICATION FOR ADMISSION / INTERVENTION:

_____

_____

_____

_____

BRIEF HISTORY:_____

EXAM FINDINGS:_____

INVESTIGATIONS DONE/ RESULTS:_____

Estimated Length Of Stay (ELOS): _____

Estimated Cost Of Service (ECOS):_____

Name of Doctor in-Charge Of Case:_____

Signature:_____