For Inpatient, Dental and Optical Preauthorization is COMPULSORY Other than taking Preauthorization TIA not liable for payment any Bill

Tacawun Cooperative Insurance
شركة التعاون للتأمين التكافلي

TACAWUN COOPERATIVE INSURANCE

Pre-Authorization and Claim Form

PART A: To be completed by the Patient / Patient's Attendant

Patient's Name		Membership No	
Employee's Name		Relation	
Employer's Name		Contact No	

Age: …… Child weight: ……

Hospital Name

DECLARATION: I confirm that the information I have given on this form is accurate, to the best of my knowledge. I hereby authorize TIA to discuss, access and obtain a copy of my health records (or any of my dependents' records) that may be requested by them or their appointed representative. I also agree that a copy of this declaration stands valid as original. I understand that in the event that terms and conditions of my plan have not been met Hospital reserves the right to recover any costs directly from the plan holder or myself.

Signature of Patient / Patient's Attendant	
Signature	**Date**

Credit Facilities will be entertained only after receiving APPROVAL from Tacawun Insurance

PART B: To be completed by the Attending Physician or Medical Practitioner

FOR PREAUTHORIZATION ONLY

Type of service	Emergency In-patient		Non-emergency		In-patient		Dental		Optical	
Admission Date:		Length of Stay		Cost (in USD)					

Findings and diagnosis

Complain:

Analyzes/ HPI:

Past medical history:

Physical examination findings:

Document the *diagnosis* in the boxes each LETTER with CAPITAL.

MEDICAL PRACTITIONER DECLARATION	**ATTENTION**	
I hereby certify that all medical information mentioned is to the best of my knowledge true and the medical services shown on this form are medically indicated & necessary for the Management of the patient medical condition. **Physician Name:** …… **Specialty:** …… **Contact No:** …… **Signature & Stamp:** ……	Please arrange to send us the **Pre-approval/take necessary steps of payment** for the above mentioned Patient as per the information provided in this form on an Urgent basis. **Hospital Stamp:** _____	**Signature of Patient / Patient's Attendant with the doctor.** **Sign**……