PRE-APPROVAL ASSESSMENT FORM FOR IN-PATIENT TREATMENT

PACIFIC CROSS

ALL SECTIONS MUST BE COMPLETELY FILLED OUT AND SUBMITTED ALONG WITH NECESSARY ATTACHMENTS FOR ELIGIBILITY ASSESSMENT. A SEPARATE ADVICE WILL BE MADE ON ITS RESULTS.

A. PARTICULARS OF CLAIMANT

Patient's Name: _____
Last Name First Name Middle Name

Birthdate: ____/____/____ (Month Day Year) The Patient is a ☐ Principal Insured ☐ Dependent Policy ID No.: _____ (of Principal Insured)

Contact Person's Details:
Name of Contact Person: _____
Mailing Address: _____
E-mail Address: _____ Tel. No.: _____ Mobile No.: _____ Fax No.: _____

B. AUTHORITY AND DECLARATION STATEMENTS

Authority: I hereby authorize Pacific Cross Insurance, Inc. and/or Pacific Cross Health Care, Inc. and all persons duly authorized and acting on their behalf to request and receive any information or document and record from any hospital, clinic, laboratory, attending physician and other health service provider, which information or document relates to any medical history, examination, laboratory test results and/or treatment in connection with this pre-approval claim, and such other matters related thereto. A photocopy of this considered an original for all intents and purposes.

Data Privacy Consent: I understand that Pacific Cross collects and uses my personal data to service and administer my insurance policy, to provide appropriate and timely Medical and Travel Services, and for the purposes provided in the Pacific Cross Privacy Statement attached to this application form (also available at www.pacificcross.com.ph). By signing this application form, I acknowledge that I have read and agree to the terms of the Privacy Statement, and understand that my data may be collected, shared, disclosed, transferred, used or otherwise processed by Pacific Cross in accordance with the Data Privacy Act of 2012, its implementing rules and regulations, and the Privacy Statement. Nothing in this form is intended to revoke or supersede any prior consent that I have given to Pacific Cross in respect of the processing activities involving my personal data.

Declaration: I declare that all particulars stated on all pages of this form are complete and true, whether written by me or anyone else on my behalf, shall be binding on me under the terms and conditions of the Policy.

_____ _____
Signature over Printed Name of Patient or of Principal Insured (if Patient is a Minor) Date

C. ATTENDING PHYSICIAN'S REPORT (To be completed by the Main Attending Physician/Surgeon only.)

1.

Required procedure or surgery	Diagnosis	Date when symptoms first appeared *(mm/dd/yyyy)*	Date of first consult *(mm/dd/yyyy)*	Date Diagnosed *(mm/dd/yyyy)*	Plausible cause of the condition

2. If confinement would be required, specify diagnosis of condition that requires hospitalization: _____
3. Any existing medical condition contributory to the conditions being treated? If "yes", please specify: _____
4. Did the sickness or injury arise out of the patient's employment? If "yes", please explain: _____
5. Is the condition due to pregnancy, childbirth or miscarriage? If "yes", specify date of commencement of pregnancy/of child delivery/of miscarriage (month/day/year): _____
6. Is the condition accident-related? If "yes", when did the accident happen (month/day/year)? _____
   Around what time? _____ What was the nature of the accident? _____
7. If procedure(s) require implantation, state name of implantable device/prosthesis/corrective device: _____
   Dates of surgical procedure(s) (month/day/year): _____

NOTE: Please attach the patient's supporting medical reports (e.g., laboratory results) as may be applicable.

Hospital: _____
Tel. No.: _____
Address: _____
_____

_____
Signature over Printed Name of the Main Attending Physician/Surgeon