Allianz

Pre Authorization request Form

1. Medical provider details:

Hospital/facility name:
Address (including country):
Email:

Telephone:
Fax:
Contact person:

2. Patient details:

Patient name:
Policy Number:

Date of birth (DD/MM/YY): --/--/--

3. Treatment details:

Signs and symptoms: _____

_____

Onset date of symptoms (DD/MM/YY): _ _ / _ _ / _ _

Diagnosis (if unknown, please state provisional diagnosis): _____

_____

Treatment plan / procedure: _____

_____

Admission date (DD/MM/YY): ___ /___ /___

Estimated length of stay: ____ Nights ____ Days

Total estimated costs: EGP _____

Official stamp of medical provider

Failure to complete this form fully will delay our ability to guarantee your treatment as we may have to revert to you or the medical provider for further information

Should you have any questions or require any assistance, please do not hesitate to email us at: preauthorization@medmark.eg. Alternatively, our Hotline is available 24 hours a day, 7 days a week on: +2(02)19247 / +2(012)2210-9494