



Looking After Life since 1847  
A Member of the Guardian Holdings Group

# PRE – CERTIFICATION FORM

Patient: \_\_\_\_\_ Age: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Referred by :- (G.P.) \_\_\_\_\_ Date of referral: \_\_\_\_\_

Referred to (Specialist): \_\_\_\_\_

Specialist/ Report: \_\_\_\_\_

Medical History & Finding: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Diagnosis: \_\_\_\_\_

Treatment/ Procedure Recommended:

\_\_\_\_\_  
\_\_\_\_\_

Laboratory

\_\_\_\_\_  
\_\_\_\_\_

COST: \_\_\_\_\_

Proposed Date of Treatment: \_\_\_\_\_

Any other information: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### PLEASE INDICATE COPIES TO BE SENT TO:

SURGEON/SPECIALIST :

HOSPITAL:

INSURED/PATIENT:

\_\_\_\_\_  
Laboratory/Representative Signature/Stamp

\_\_\_\_\_  
Date

\_\_\_\_\_  
Insured/Patient's Signature

\_\_\_\_\_  
Date

**NOTE: Treatment must be completed within 30 days from the date of this authorisation**