BARAKA INSURANCE
we protect you

HEALTHCARE+ CLAIM AND PRE-AUTHORIZATION FORM

(Must be used for Dental, optical and inpatient. If the form is not filled,

No payment will be processed.

SECTION;1-To be completed by the Patient / Patient's Attendant			
Patient's Name		Policy No	
Employee's Name		Relation	
Employer's Name		Contact No	

Is the claim covered by other Insurance? If Yes, please enclose details	**Yes**	**No**
Did you get admitted for this kind of illness in any Hospital within last three months' time?	**Yes**	**No**
If **YES**, mention the name of the Hospital		

DECLARATION: I confirm that the information I have given on this form is accurate, to the best of my knowledge. I hereby authorize BTI 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. If the terms of the conditions set by TBI and hospital are not met, reserves the right to recover any costs directly from the plan holder or myself.	**Signature of Patient / Patient's Attendant**
	Signature / **Date**

SECTION-2 : To be completed by the Attending Medical Doctor

FOR PRE-APPORVAL ONLY

Pre-Authorization Request for	**Emergency In-patient** **Non-emergency In-patient** **Dental** **Optical** **M.R.I. (IP/OP)** **CT scan (IP/OP)** **Others (Pls. Specify) (IP/OP)**

Admission Date		Length of Stay		Estimated Cost (in USD)	

☐ **Sickness**	☐ **Acut**	☐ **Chroni**	☐ **Congenital/Heredita**	☐ **Work**		☐ **Pregnan**
☐ **Accident** (State Nature of						
☐ **New Visit**	☐ **Follow-up**	☐ **Outpatient(O**	☐ **Emergency**	☐ **Day**	☐ **Denta**	☐ **Optic**
Diagnosis/treatment						

MEDICAL PRACTITIONER DECLARATION 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's medical condition. **Physician Name:** **Specialty: Contact No.:** **Signature & Stamp:**	**ATTENTION** Kindly arrange to send us the **Pre-approval** for the above-mentioned patient as per the information provided in this form on an urgent basis. **Authorized Signature & Date** / **Hospital Stamp**

Mogadishu: (252) 61 2464864
Hargeisa: (252) 63 7555597
Garowe: (252) 907 685 676
Nairobi: (254) 746 668488

Giyaajo Business Center, km4
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Road No.1, 26 June, Hargeisa-SomaliaLand
Road-Global-Garrowe
First Flor Hotel Kideleshwa Nairobi Kenya

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