

## Medical Claim Form / Pre-Authorization

Please fill all sections and use separate form per member per visit.

### A: Patient information (to be completed by member/patient/ guardian only)

Patient's Name: .....

Date of birth:..... Employee Name: .....

Patients relationship with employee:.....

Company/ employer:..... Membership number:.....

Telephone No.....email.....

**DECLARATION** I agree and accept that Baraka Insurance and its appointed representatives have the right to request past, present, and future medical information from any third party, including providers and medical practitioners, in relation to this claim or any other related claim. I also declare that, to the best of my knowledge, all the information provided on this form is accurate, and I understand that Baraka Insurance will rely on the information provided as such. I understand that if I purposefully misrepresent anything or omit any important information, the Hospital has the right to demand payment directly from me or the plan holder. Signatory: member or guardian: ..... Date: .....

### B: Clinical information (to be completed by attending medical practitioner or consultant)

Provider Name: ..... Tel .....

Diagnosis: .....

Brief History and Findings: .....

#### FOR PREAUTHORIZATION ONLY

Pre-Authorization Request for	<input type="checkbox"/> Emergency In-patient <input type="checkbox"/> Non-emergency In-patient <input type="checkbox"/> Dental <input type="checkbox"/> Optical				
	<input type="checkbox"/> M.R.I. (IP/OP) <input type="checkbox"/> CT scan (IP/OP) <input type="checkbox"/> Others ( Pls. Specify) (IP/OP)				
Admission Date		Length of Stay		Estimated Cost (in USD)	

Doctor's Name: ..... Tel. ....

I hereby confirm that the information provided above is correct and true to the best of my knowledge.

Date: ..... Doctor's Signature & Stamp: .....