Pre-Authorization Form

Please note:

The Pre-Authorization request should be submitted and received by us at least 5 working days prior to the scheduled treatment. The treatments and/or services requiring Pre-Authorization are listed in the policy contract. Where Pre-Authorization is required and not obtained, benefits may be declined or reduced.
If it is not possible to request Pre-Authorization in the event of an emergency, we still expect to be notified within 24 hours by you, your family, your treating doctor, or hospital.

Failure to complete this form fully or furnish the relevant documentations may delay our ability to process your request. Please note that we reserve the rights to request additional documents or information as we deem necessary.

Please complete this form clearly in BLOCK letters.

You may submit the completed pre-authorization form, with all relevant supporting documents, using one of the methods below:

- Mail:
  Safe Meridian Claim Department
  10 Chang Charn Road, #04-01
  Singapore 159639
- Email (limit size 8MB):
  Send attachments to
  fwdclaims@safemeridian.com

1 Patient Information

Name of Patient:

Member Number: NRIC/Passport Number:

Date of Birth (dd/mm/yyyy): Gender: ☐ Male ☐ Female

Contact Person (please specify who should be contacted regarding the progress of this Pre - Authorization request)

Name (if different from above):

Relationship to patient (e.g. self, spouse, parent):

Email Address:

Telephone Number (+ country code): Mobile Number (+ country code):

Is the treatment due to a work-related accident or arising from duties of employment? ☐ Yes ☐ No
If 'Yes', please provide details of the accident and injuries sustained:

Are there any other insurance policies in force, or has compensation been received or will be received from a third party? ☐ Yes ☐ No
If 'Yes', please specify the name of the insurer/third party, product name (if applicable), and amount compensated:

2 Type of Treatment

This section must be completed by the doctor responsible for the patient's treatment.

Is this an Emergency admission? ☐ Yes ☐ No

If 'Yes', please provide details of the accident or illness, and the treatment planned:

Does the planned treatment include any of the following? (Please tick those applicable)

☐ Inpatient/Day-Care	☐ CT/MRI/PET scans	☐ Cancer treatments	☐ Kidney Dialysis
☐ Delivery	☐ Physiotherapy	☐ Rehabilitation	☐ Nursing Care at home
☐ HIV/AIDS treatments	☐ Hormone Replacement Therapy	☐ Others, please specify:	

3 Treatment Details

This section must be completed by the doctor responsible for the patient's treatment. If additional treatments are necessary, extensions of this authorization are required, or costs of treatment exceed the approved limit, we must be notified. Please note that all invoices should be submitted within 60 days of patient discharge, unless special arrangement has been agreed between us and the healthcare facility.

(A) Please provide full details of the medical condition, signs, and symptoms:

(B) What date did the patient first report consulting a doctor for this condition (dd/mm/yyyy)?

(C) What date did the patient first report experiencing symptoms related to this condition (dd/mm/yyyy)?

(D) Diagnosis (if unknown, please state the provisional or working diagnosis):

Is this diagnosis: ☐ Confirmed ☐ Provisional/Differential/Working ICD 10 code:

(E) Underlying cause(s), if known:

(F) Full details of proposed treatment/surgery/procedure:

Procedure code:

Applicable to Pregnancy cases only:

First day of the last menstrual period (dd/mm/yyyy):	Estimated Date of Delivery (dd/mm/yyyy):
Is the birth of a single baby expected? ☐ Yes ☐ No	Delivery method: ☐ Normal/Vaginal ☐ Caesarean
Reason (if delivery method is not normal):	
Is the pregnancy a result of assisted conception treatment(s)? ☐ Yes ☐ No	If 'Yes', please provide details:

4 Expected Treatment Costs

This section is to be completed by the doctor responsible for the patient's treatment, or by the receiving hospital.

Estimated Treatment Costs:

Proposed admission date (dd/mm/yyyy):	Estimated length of stay: ☐ nights(s) ☐ day(s)

Is a fixed charge or package rate being offered? ☐ Yes ☐ No

If 'Yes', please indicate the currency and package rate:

If 'No', please indicate the currency and total estimated costs, and breakdown the planned services as detailed below:

Surgeon's fee:	Type of Hospital Room:
Anesthetist's fee:	Daily Room Rate:
Operating theatre cost:	Other charges:
	Total estimated cost:

Healthcare Facility Information:

Name of Facility:	Type of Facility: ☐ Hospital ☐ Clinic
Address:	Country:
Contact Person:	Email Address:
Telephone Number (+ country code):	Fax Number (+ country code):

Medical Practitioner Declaration

Name of Medical Practitioner:	Official stamp:
Specialty/Position:	
Email Address:	
Telephone Number (+ country code):	
Signature of Medical Practitioner:	
Date (dd/mm/yyyy):	

5 Patient Data Protection Notice

By signing this form, you confirm you have read, understood, agreed, and consented to Safe Meridian:

- collecting, using, processing, and/or disclosing your personal data;
- collecting personal data about you from sources other than yourself and using, processing, and/or disclosing the same; and
- disclosing and/or transferring your personal data to the participating Insurers, Claim Administrator, Assistance Company, third-party service providers or vendors, and our professional advisors, wherever they are sited,

for the purposes stated in Safe Meridian's Data Privacy Policy.

If you have declared any personal data relating to other individuals, you agree to inform the individual(s) about the content of our Data Privacy Policy, and obtain prior consent to act on their behalf to allow for the collection, use, disclosure, and transfer of their personal data in accordance with our Data Privacy Policy.

For details of our Data Privacy Policy, please visit our website: https://www.safemeridian.com

6 Declaration & Authorization

Please read the following carefully, and sign below if you understand and accept:

1. I declare that, to the best of my knowledge, all information supplied in this claim form is true, accurate, and complete.
2. I understand and agree that should I make any false, fraudulent or intentionally exaggerated claims, or withhold material facts whatsoever in respect of this claim, the policy will be cancelled without refund of the premiums already paid, and I shall forfeit all rights to recover therein.
3. I consent to the handling of my personal data declared and provided in this claim form, in accordance with the Patient Data Protection Notice as described above.
4. I authorize any hospital, healthcare provider, and/or doctor who has ever attended or treated me, to provide Safe Meridian, the Insurer or their appointed authorized representatives, with any and all information and medical records relating to any illness or injury, as may be necessary to access this claim.
5. I authorize _____ to act for and on my behalf in relation to the administration of this claim, which may include the disclosure of sensitive personal information.
6. I agree that a photocopy, facsimile or scan of this authorization shall be considered as effective and valid as the original.

Name of Patient:	Signature of Patient:	Date (dd/mm/yyyy):
Name of Policyholder:	Signature of Policyholder (if patient is under 18):	Date (dd/mm/yyyy):