HSBC Life Shield

PRE-AUTHORISATION FORM

All details in this form must be duly completed and signed by both the doctor and the patient. (If the policyholder is not the patient, the policyholder must sign the form as well.)

Please submit this form prior to the patient's commencement of treatment, together with any complete medical reports and laboratory test results held in respect of the patient, via:

- HSBC Life Shield Panel Specialist's Appointment and LOG Hotline: 6-3425-292
- Email to admin@hsbclifeshield.com.sg

Particulars of Patient

Name: _____

NRIC No: _____ **Contact No:** _____

Particulars of Policyholder (if Not the Patient)

Name: _____

NRIC No: _____ **Contact No:** _____

Relationship with Patient: _____

Authorisation of Patient / Policyholder

1. I/We hereby authorise:
    a. HSBC Life (Singapore) Pte. Ltd. ("HSBC Life") to request from any hospital, physician, person or organisation, information with respect to any illness, injury, medical history, consultations, prescriptions or treatment, and copies of all hospital or medical records concerning the Patient at any time and authorise the prior mentioned persons or entities to disclose all such information to HSBC Life.
    b. HSBC Life to collect, use, and disclose my/our personal data for the purpose of processing pre-authorisation and such other purposes (ancillary or otherwise) related to the administration of insurance coverage and claims adjudication.

2. I/We agree that HSBC Life reserve the right to recover any outstanding amount from the Policyholder should the Patient's total medical expenses exceed policy coverage or are excluded from policy.

3. I/We hereby declare that all the information provided in this form (including any attachments) is true and complete. I/We also declare that I/we have not withheld any material fact from HSBC Life. In the event of any withholding or non-declaration of any medical information from HSBC Life, HSBC Life reserves the right to decline the LOG.

4. I/We understand that a photocopy of this authorisation shall be considered as effective and valid as the original.

Signature of Patient _____ **Date:** _____

Signature of Policyholder (if not the Patient): _____

PRE-AUTHORISATION FORM TO BE COMPLETED BY ATTENDING DOCTOR
(Indicate "NA" if not applicable.)

Fill dates in format "DDMMYYYY"

Name of Patient	**NRIC / FIN No**

A. Details of Hospitalisation

Name of Principal Doctor and Clinic	**Name of Hospital / Surgery Centre**

Preferred Ward Type

Private

□ Day Surgery □ 2 Bed
□ Standard Single Bed □ 4 Bed
□ Others:

Public/Restructured

□ Day Surgery (subsidised) □ Class B1/B1+
□ Day Surgery (non-subsidised) □ Class B2/B2+
□ Class A □ Class C

Date of Admission	**Est. Length of Stay** (No. of days)

Is the condition typically managed on an outpatient basis? If Yes, please provide reason for this hospitalisation.

□ No □ Yes, reasons are:

Date of first consultation of symptoms	**Date of diagnosis/ provisional diagnosis**	**Diagnosis / Provisional diagnosis in ICD 10 AM with description**

Date of onset of symptoms / Duration of symptoms	**Description of symptoms**

Did the patient come to see you with a referral letter?

□ No □ Yes

(If a referral letter is available, please attach a copy to speed up the pre-authorisation process.)

Based on the information available to you, does the patient have any of the following major co-morbidities? *(Note: Only co-morbidities that have impact on the patient's treatment, impact on the duration of hospitalisation, or which are medically related to the patient's condition, need to be indicated.)*

Based on the information available to you, is the event for which pre-authorisation is being requested:

□ For a routine check-up/screening
□ Related to a clinical trial/study
□ Related to self-inflicted injuries/attempted suicide
□ Related to alcohol/drug abuse
□ Related to a congenital anomaly/genetic disorder
□ Related to a mental/psychiatric disorder
□ Related to an elective cosmetic procedure
□ Related to a dental procedure
□ Related to an STD or HIV/AIDS

Name of Clinic and Doctor who had treated the patient for the above comorbidity, available

Comorbidities	**Date of diagnosis, if available**
□ Cancer	
□ Stroke, Heart Failure, Cardiovascular Disease	
□ Diabetes	
□ Hyperlipidaemia	
□ Hypertension	
□ Kidney Failure	
□ Other Significant Comorbidities that impact the patient's care (Please state):	

B. Best Estimated Costs		S$
1. Total Professional Fees Breakdown as:		.....
TOSP Code and Description:		
Surgeon fees		**S$**
Anaesthetist fees		**S$**
TOSP Code and Description:		
Surgeon fees		**S$**
Anaesthetist fees		**S$**
TOSP Code and Description:		
Surgeon fees		**S$**
Anaesthetist fees		**S$**
2. Total Attendance Fees		.....
3. Total of Other Fees (E.g. Secondary treating doctors' fees, surgical implants, medical consumables, and other charges.) Breakdown as:		
a.		**S$**
b.		**S$**
c.		**S$**
d.		**S$**
		.....
4. Total Hospital Charges		.....
5. Total Bill Size = 1 + 2 + 3 + 4		.....

C. Principal Doctor's Declaration & Signature

1. I represent and warrant that:

(a) I have personally examined and treated the Insured (i.e. patient) in respect of the medical condition described above and that the information stated above represent my genuine and honest opinion of his/her condition and my recommended treatment; and

(b) the answers given above are true, accurate and complete to the best of my knowledge and belief and that no information has been withheld.

2. I agree and authorise HSBC Life (Singapore) Pte. Ltd. to release this medical information, with the patient's consent if such disclosure is required by the Financial Industry Disputes Resolution Centre Ltd (FIDReC) of Singapore or any claim dispute resolution organisation.

Official Stamp of Hospital / Clinic

Name of Doctor: _____

Doctor's MCR: _____

Doctor's Signature and Date: _____