Jubilee
HEALTH INSURANCE

HOSPITALIZATION PRE-AUTHORIZATION FORM

JUBILEE HEALTH INSURANCE LIMITED
Head Office:
Jubilee Insurance House, Wabera Street,
P.O. Box 6694 - 00100 GPO, Nairobi, Kenya
Tel: +254 20 328 1000
Call Centre: +254 709 949 000
Email: talk2ushealth@jubileekenya.com
www.jubileeinsurance.com

DIRECTIONS:
Please read carefully and fill out the entire form.
1. *Answer all questions otherwise there may be delays in preauthorization of the admission and/or bills/invoices may not be paid. (Complete in CAPITAL Letters).*
2. *A duly completed and signed inpatient form should be sent to Jubilee Health Insurance within 24hrs of admission of one of its members to your hospital.*
3. *All FIELDS MUST be completed to avoid delay or rejection of the authorization.*

TO BE FILLED BY THE INSURED/PATIENT

Patient Name:

Gender: ☐ Male ☐ Female Age: Years _____ Months _____

Date of birth: *day/month/year* Mobile No. Member Number:

Scheme:

Name of employee:

Relation to insured: ☐ Self ☐ Spouse ☐ Child

TO BE FILLED BY THE TREATING DOCTOR/HOSPITAL

Name of hospital:

Date of admission : *day/month/year* Time

Is it an emergency /a planned hospitalization event? ☐ Emergency ☐ Planned ☐ Day Case

Presenting complaints:

Relevant clinical findings:

Duration of the present ailment:_____

Provisional diagnosis:

Past history of present ailment if any:

Reason for admission (explain the specific admission criteria that has been met)

Date of diagnosis:

Proposed line of treatment:
☐ Medical management ☐ Surgical management ☐ Intensive care ☐ Investigative care

Provide details of baseline investigation/medical management

If investigation/medical management provide details

If surgical, name of surgery:

If other treatments provide details:

In case of accident/injury:
Is it RTA ☐ Yes ☐ No Details of injury?

Date of Injury: day/month/year

Injury/Disease caused due to substance abuse/Alcohol consumption ☐ Yes ☐ No
Attach copy of blood alcohol level results

In case of **maternity** ☐ G ☐ P ☐ L ☐ A ☐ EDD _____ Length of stay_____ (Days)

Present/Past history of any chronic illness if yes, since (month/year)

- ☐ Diabetes
- ☐ Heart disease
- ☐ Hypertension
- ☐ Hyperlipidemias
- ☐ Osteoarthritis
- ☐ Asthma/COPD/Bronchitis/TB
- ☐ Cancer/Tumor/Cyst
- ☐ Alcohol/Drug abuse
- ☐ HIV/Immuno suppression
- ☐ Thyroid disease
- ☐ Congenital/Recurrent
- ☐ Psychiatric condition
- ☐ Paralysis/CVA/Epilepsy

Any other ailment, give details:

Specialty	Name of the Doctor	Charges
Physician		
Surgeon		
Anesthetist		

Estimated cost of treatment: Estimated length of stay:

PATIENT'S DECLARATION

1. ☐ I hereby authorise the hospital/physician to submit all the details and original documents requested for and pertaining to hospitalization to Jubilee Health Insurance.
2. ☐ Payment to the hospital is governed by the terms and conditions of the policy. In case Jubilee Health Insurance is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.
3. ☐ I hereby confirm that the information provided is accurate and correct to the best of my knowledge and I am aware that any fraudulant, false, intentionally exaggerated or unfounded, suppressed information provided in respect to the claim, may cause the claim to be forfeited and not payable/recoverable by Jubilee Health Insurance.
4. ☐ As part of managing my health benefit and treatment, I do understand that Jubilee Health Insurance may send another qualified doctor to review my care as second opinion at any point of my care in the hospital.

Patient's/Insured's name: _____ Patient's/Insured's signature: _____

DOCTOR'S DECLARATION

1. We have no objection to any authorized Jubilee Health Insurance official verifying documents pertaining to hospitalization.
2. We agree that Jubilee Health Insurance will not be liable to make payment in the event of any discrepancy between the information provided in this form and the discharge summary or other relevant documents.
3. We agree to provide clarifications for the queries raised regarding this hospitalization. In addition, medical reports will be provided within 24 hrs upon request.
4. We have no objection to Jubilee Health Insurance sending another qualified doctor for second opinion in support of the client's health benefit management and treatment.

Doctor's name: _____ Doctor's signature: _____

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

1. Detailed discharge summary and all bills from the hospital.
2. Radiological test report from Radiologists and Surgeon's report and bills.
3. Baseline investigations before admission.