APA INSURANCE
GENERAL • LIFE • HEALTH

INPATIENT PRE-AUTHORISATION /APPROVAL REQUEST FORM

PLEASE FILL OUT THIS FORM CLEARLY AND COMPLETELY IN BLOCK LETTERS

Please read every section carefully and fill out the form appropriately.

1. All fields MUST be completed to avoid delay or rejection of the authorisation.
2. A duly completed and signed outpatient form should be sent to care.team@apainsurance.org
3. For more information, please contact us through 0709 912 888 / 0722 200 100 / 0713 200 100 / 0720 600 577 / 0734 600 577.

Name of Hospital _____ Tel & Fax No_____

Name of Medical Scheme Provider: _____ Tel & Fax No_____

Name of Company/Client _____

Policy/Membership No _____

Employee's Name _____

Staff No. (If available) _____ Gender: Male ☐ Female ☐

Patient's Name _____ Date of Birth: D D M M Y Y Y Y

Relation to Insured: Self ☐ Spouse ☐ Child ☐

Email Address _____

Is patient an NHIF Member? Yes ☐ No ☐ If Yes, indicate NHIF No: _____

Is patient insured under any other medical scheme, workmen's compensation or personal accident? Yes ☐ No ☐

If so, give particulars: _____

Hospital Registration No: _____ ID No. _____

Provisional/Final Diagnosis: _____ Date: D D M M Y Y Y Y

When was the condition first diagnosed:_____

When was the condition last treated:_____

Causes of illness(es): _____

_____ (Or any known underlying condition)

Is the condition Congenital, Chronic or Recurring? _____

Surgical: Yes ☐ No ☐

Is this the first ever Caesarean? Yes ☐ No ☐ Emergency ( ) Non-Emergency ( ) Booking Letter/EDD ( )

Approval request for (Tick as appropriate)

Others (Please Specify):_____

Investigations done: _____

Past medical history: _____

Inpatient Management: _____

Estimated Hospitalisation Duration:_____

Estimated Cost of Treatment: _____

Surgeon's Fees: _____ Anesthetist Fees:_____

Doctor's Name: _____ Tel: _____

Doctor's Declaration

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

Date: D D M M Y Y Y Y

Doctor's Signature & Stamp: _____

PATIENT'S DECLARATION

Authorisation to obtain and use information

Personal data refers to all information that may directly or indirectly identify you. In order to provide you with products and services, we need to collect, use, share and store your personal data. This may include information provided by you or obtained from third parties. The information may be used to assist us in providing the service you are applying for and shall be used in fulfillment of contractual obligations. We may also use the information to advise you of other products and services provided by us, to confirm, update and enhance records, and to establish your identity. The data collected may be shared/transferred/stored/processed within or outside the Kenyan jurisdiction. Any reference to "We" or "Us" will mean Apollo Group. Refer to our website **www.apainsurance.org** to see the entities under Apollo Group.

I authorize APA Insurance to obtain and use my personal information as per the above. Yes ☐ No ☐

Note: In case you would like to revoke the consent, kindly send an email to **privacy@apollo.co.ke.**

I _____do hereby authorise any doctor, hospital, clinic or medical provider, any other company, institution or person who has record or information about me and/or my family members to provide my insurer with complete information including copies of their records with reference to my sickness or accident any treatment, examination, advice or hospitalization. I have also been advised of and have understood the various exclusions. Any photocopy of this authorisation shall be taken as the original copy.

Patient/Parent/Guardian's Name (PRINTED): _____ Phone No: _____

Patient/Parent/Guardian's Signature: _____ Date: D D M M Y Y Y Y