Pre-Authorisation Form

Pre-Authorisation form and related correspondence must be forwarded to Generali

Attention: Medical Management
Fax: +1 905 669 2524
Email: medical@generalihealth.com

GENERALI Global Health

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Any hospital admission or hospital accommodation (including day admission) for surgery, diagnostic tests, oncology treatment, psychiatric treatment, organ transplant and dental extractions. Any service relating to pregnancy and pregnancy complications, elective home healthcare, mental health treatment, audiology services, repatriation of remains and air ambulance.

Please allow at least 2-5 business days for the Pre-Authorisation to be processed. You must notify us at least 5 business days prior to a scheduled or elective admission or treatment plan. If advance notice cannot be provided due to an emergency, we must receive notification from you or your representative within the later of 48 hours or the end of the first business day following the beginning of the service. If Pre-Authorisation is not obtained, cover for services received may be subject to a denial or a reduction in your benefits to 75%.

SECTION A - POLICY HOLDER (PRINCIPAL MEMBER) INFORMATION

First Name	Last Name	Membership Number

Date of Birth	Address	Telephone (include area code)
MM/DD/YYYY		( )

SECTION B - PATIENT INFORMATION

First Name	Last Name	Date of Birth
		MM/DD/YYYY

Patient Sex	Patient's Relationship to Policy Holder	Patient's Employer (if Spouse)
❑ Male ❑ Female	❑ Spouse ❑ Child ❑ Other _____	

If the patient is covered by another health plan, please provide Insurance Company Name and Address

SECTION C - PROVIDER INFORMATION - To be completed by the Provider

Attending Physician's Name	Telephone (include area code)	Fax (include area code)
	( )	( )

Attending Physician's Address

Referring Physician's Name and Address	Telephone (include area code)	Fax (include area code)
	( )	( )

SECTION D - CLINICAL INFORMATION - To be completed by the Provider

Diagnoses/ ICD-9 code and Description

Date of onset of Illness/Symptoms	If pregnancy related, indicate if this is an assisted pregnancy	Was the illness or injury related to an accident?
MM/DD/YYYY	❑ Yes ❑ No	❑ Yes ❑ No

Recommended Procedure/ CPT Code and Description	Date of Procedure
	MM/DD/YYYY

Is Assistant Surgeon required at procedure?	Is this procedure	Est. Cost of Procedure	Facility Name where procedure will be performed
❑ Yes ❑ No	❑ Admission - Approx. LOS _____ ❑ Outpatient Surgery ❑ In-office Procedure	$	

Clinical Details (attach additional clinical information)

I declare the statements made herein are true and complete to the best of my knowledge. I understand that any misrepresentation, incorrect or concealed information or failure to fully complete all sections may affect the benefits provided; in addition, I understand that submitting this form containing false or deceptive statements is considered to be fraudulent activity.

Signature of Provider	Date
X	MM/DD/YYYY

SECTION E - FOR GENERALI USE ONLY

Pre-Authorisation	❑ Approved	❑ Denied	❑ Deferred	LOS Authorized:

Pre-Authorisation Number	Comments

Coverage	Deductible	Professional Services	Facility Services
	$		
	Deductible Remaining $		

Reviewed By	Date
	MM/DD/YYYY

NOTE: Pre-Authorisation APPROVAL IS ONLY VALID FOR ONE MONTH FROM DATE INDICATED. This is not a guarantee of payment. Benefits will be subject to all policy requirements being in effect at the time services are rendered.