MetLife

Pre-approval/ Approval Form

PART A: To be completed by the Patient / Patient's Attendant			
Patient's Name		Date of Birth	
Employee's Name		ID No.	
Insurance Plan Name		Policy No.	
Type of Plan		Expiry Date	
Organization			

Is the claim covered by other insurance? If yes, please enclose details	Yes ☐	No ☐
Did you get admitted for this kind of illness in any Hospital within last three months' time?	Yes ☐	No ☐
If yes, mention the name of the Hospital		

Direct Billing / Credit Facilities will be entertained only after receiving Pre-approval / Approval from the Insurance Company

DECLARATION	Signature of Patient / Patient's Attendant	
I confirm that the information I have given on this form is accurate, to the best of my knowledge. I understand that in the event that terms and conditions of my plan have not been met Hospital reserves the right to recover any costs directly from the plan holder or myself.		
	Signature	Date

PART B: To be completed by the Attending Physician or Medical Coordinator			
Name of the Consultant			
Diagnosis / Condition			
Treatment / Procedure			
Estimated Cost (in BDT)			
Admission Date		Proposed Length of Stay (No. of Days)	

ATTENTION:

Dear Sir or Madam:
Please arrange to send us the approval for the above mentioned patient as per the information provided in this form on an urgent basis.

Thanks & Regards,

Authorized Signature & Date — Seal