



Pre-Authorization Request Form

Please fax to Medical Claims Section – Fax : 04-2688323

For Enquiries please contact : 8004746 or 050-4585527/050-4543778 (24hr. HELPLINE)

Email: medpar@tameen.ae or Visit our website at www.oicem.com

(Please PRINT or FILL IN BLOCK LETTERS)

PAR NO. : Your Ref. No. : Date :

Provider Name : Contact Person : Tel. No. : Fax No. : E-mail :

Patient's Name : OIC Card No. :

Main Complaints & Duration :

Diagnosis :

Dates of Previous Treatment / Consultation for this Disability :

Proposed Date of Admission (if applicable) :

Approval Requested for : a) In-Hospital ~ Admission Surgery b) CT Scan c) MRI d) Out-Patient ~ Surgery e) Physiotherapy No. of Sessions : f) Others (Please Specify) : g) Specify - Emergency : (Yes / No) If Yes, state Date of Admission : (Please attach detailed medical report with clinical findings wherever applicable)

Table with 2 columns: Estimated Cost and FOR OIC USE. Rows include Room Charges, Physician / Surgeon, Operation Theatre, Anaesthesia, Investigations, Consumables, Pharmaceuticals, Others, and TOTAL (Dhs.).

Attending Doctor's Name : Dr. Stamp & Signature :

FOR OIC USE ONLY

OIC Decision : Attended by : As per Reasonable & Customary Charges: Signed : Date : (ANY APPROVAL IS SUBJECT TO POLICY TERMS & CONDITIONS&VALID OIC HAELTHCARD)

Patient's Signature : Date : (after completion of treatment)

N.B : Validity : Pre-Authorization should not be sought before 7 days of planned treatment Note : Copy of Pre-Authorization to be attached while submitting the claim.

