PRE-AUTHORISATION FORM FOR LOG

Please furnish the following information / documents to Ulink Assist:

i. Kindly complete ALL sections of the form and attach the relevant medical documents where required
ii. A new form should be submitted for each separate visit, illness, or injury
iii. Incomplete forms and attachments may result in rejection or delay of LOG

Section A: Patient information

Name of patient	
Policy number	
NRIC	
DOB	
Admission date	
Hospital name	
Doctor name	
Room type / ward type	

Section B: Contact details

Email address	
Contact number	

Section C: Medical details

a) Type of visit (choose one)

☐ Inpatient due to accident

☐ Inpatient due to medical reasons (non-accident)

☐ Inpatient due to miscarriage

☐ Outpatient

b) Diagnosis / medical condition

c) Patient will undergo / has undergone surgery

☐ Yes ☐ No

If yes, kindly attach the relevant medical reports and investigation results.

d) Has the patient undergone medical treatment for the same or related condition(s) in the past?

☐ Yes ☐ No

If yes, kindly attach the relevant medical reports and investigation results for past medical treatments.

e) Length of hospitalisation:

Admission / appointment date: ______ Expected discharge date: ______

Day surgery? ☐ Yes ☐ No If yes, type of surgery: ______

f) Estimated hospitalisation cost MMK ______

Kindly attach cost estimation form from the hospital.

g) Additional attachments, if any (e.g. referral letter, police report for accident, biopsy report etc.)

Section D: Declaration, consent and authorisation

By completing the form, I hereby declare that:

a. I am the patient, or the patient’s parent or guardian if the patient is under 18 years of age.
b. All information on this preauthorisation form is true and correct based on the best of my knowledge.
c. I authorize my treating doctor(s), clinic, hospital or any other medical provider to provide access and furnish all necessary and relevant reports and/or medical and invoice information pertaining to my personal data and medical condition (these may include information regarding past medical history, psychological notes, drug or alcohol abuse notes, AIDS and other sexually transmitted disease related information) to Ulink Assist Co. Ltd., including its associate companies, partners and affiliates, as may be required.
d. I further authorise Ulink Assist Co. Ltd., including its associate companies, partners and affiliates to have access, to use, to receive and to share for valid purpose such reports and/or information obtained from myself, authorised representatives, treating doctor(s), clinic, hospital or any other medical provider for the purpose of evaluating and providing my medical care, assistance services or healthcare benefits administration services, as well as to coordinate, assess and determine my entitlements, benefits and/or reimbursements in connection with my health or medical insurance coverage.
e. I acknowledge that the information submitted herein shall be used only for the pre-authorisation of direct settlement by Ulink Assist Co. Ltd. with the clinics/hospitals for any eligible and approved charges relating to my approved medical treatment. I agree to pay any excess amounts and uncovered medical expenses (if any) to clinics/hospitals or Ulink Assist Co. Ltd. within 7 business days from date of request. The actual covered amount is subject approved based on the information provided in the pre-authorisation form, actual diagnosis, eligible policy benefit, exclusion clause, terms and conditions stated in the policy document.

Signature		Date of consent	
Print name		Relationship to patient (if applicable) *	

* If this authorisation is being signed by a personal representative on behalf of the patient