# Request for
# Pre-Certification Form

*To be completed by the Insured*

RoyalStar House
John F. Kennedy Drive
P.O. Box EE-15606
Nassau, Bahamas

NEW PROVIDENCE
LIFE INSURANCE COMPANY LIMITED

## Part I: Primary Insured Information

| Last name | First name | I. |
|---|---|---|
| Customer number | Email address | Phone *(Home/Cell)* |
| Address | | DOB *(Day/Month/Year)* |

## Part II: Claimant Information

| Last name | First name | I. |
|---|---|---|
| DOB *(Day/Month/Year)* | Sex ☐ Female ☐ Male | Relationship to primary insured ☐ Self ☐ Spouse ☐ Child |

## Part III: Accident Related Services

| Date of injury or accident *(Day/Month/Year)* | Did the injury occur while working? ☐ Yes ☐ No | Is injury due to automobile accident? ☐ Yes ☐ No |
|---|---|---|
| How did injury or accident occur? | | |

## Part IV: Illness Related Services

| Current diagnosis | Specialty of attending physician |
|---|---|
| Date first symptoms occurred *(Day/Month/Year)* | Address of attending physician |
| Name of treating physician | Phone number(s) |
| Specialty of treating physician | Name of any other physician you have seen |
| Address of treating physician | Specialty of any other physician you have seen |
| Phone number(s) | Address of any other physician you have seen |
| Name of physician attending for current condition *(if is different from the treating Physician)* | Phone number(s) |

I declare the answers to the questions are true and complete to the best of my knowledge and belief. I authorize any physician, medical institution, insurance company, employer, labor union, or association to release information to MWG International as is required to properly process this exam. A photostatic copy of this authorization shall be considered valid as the original.

_____ Date _____ / _____ / _____

Insured Signature (patient) Day Month Year
*(If the Insured (patient) is underage, the primary insured shall sign this form)*

# Request for Pre-Certification Form *(continued)*

*To be completed by the treating physician*

## Part V: Patient Information

| Name of patient | DOB *(Day/Month/Year)* | Sex ☐ Female ☐ Male |
|---|---|---|

| Date on which patient first consulted you *(Day/Month/Year)* | Date on which first symptom or accident occurred *(Day/Month/Year)* | Date on which patient first consulted you for symptom *(Day/Month/Year)* |
|---|---|---|
| | | |

## Part VI: Medical History

| History of present illness | |
|---|---|
| Past Medical/Family/Social history | |
| Physical examination | Date first symptoms occurred *(Please attach results)* |
| Diagnosis *(ICD-9)* | Plan or treatment *(CPT-Code)* |
| Hospital to perform the treatment | Date to perform the treatment *(Day/Month/Year)* |
| Address of treating physician | Specialty of any other physician you have seen *(Please list any other physician consulted for same condition)* |

**FEES:** Surgeon *(if applicable)* _____ 1st Assistant *(if applicable)* _____ Anesthesiologist *(if applicable)* _____

_____ Date _____ /_____ /_____

Signature of physician Day Month Year

_____

Medical license number

# Request for Pre-Certification Form *(continued)*

*To be completed by the treating physician*

## Part VII: Maternity Precertification

| | |
|---|---|
| Uterus enlarge measurement | Date of last menstrual period *(Day/Month/Year)* |
| Time period of pregnancy | Expected date of delivery *(Day/Month/Year)* |
| Maternity progress | |
| **FEES:** Normal Delivery<br>Surgeon _____ Anesthesiologist _____ 1st Assistant _____ Pediatrician _____ | |
| **FEES:** Cesarean<br>Surgeon _____ Anesthesiologist _____ 1st Assistant _____ Pediatrician _____ | |
| Hospital for delivery or cesarean | |
| Physician name | Phone |
| Address | |

_____ Date _____ /_____ /_____

Signature of physician Day Month Year

_____

Medical license number

**NOTE:** *If additional information is needed, it will be requested by the Administrator.*

**GUARANTEE OF PAYMENT AND PRECERTIFICATION PROCESS**

Precertification must be completed prior to a hospital admission or confinement.

1. In the event of a non-emergency hospital confinement, the insured or the admitting physician must contact the administrator a minimum of fifteen (15) days prior to admission to certify the admission based upon proven medical necessity. The administrator must receive complete medical records from the treating physician.

2. In the event of an emergency admission, the hospital in which the insured is confined must contact the administrator within forty-eight (48) hours of admission and/or confinement, regardless of whether or not said individual has been discharged.

3. In either event of hospitalization, the administrator must receive complete medical information to evaluate the case, including the admission report from the hospital, diagnosis, treatment required, and expected date of discharge. If surgery was required, the administrator will need the surgeon's report and the anesthesiologist report.

4. When notified in advance, and if the claim is considered admissible, the administrator will send a guarantee of payment to the hospital in accordance with the certificate conditions the primary insured has chosen. The administrator will settle the claim directly with the hospital. Failure to comply will result in reduced benefits.