Tel: + 66 2 494 3600



PRE-APPROVAL FORM

For precertification of this case, please provide the following information, which will be handled in strict confidence by our medical team. Please be aware that it may be necessary to request further information before completing the precertification process. Thank you.

1 PATIENT	INFORMATION	
Surname	:	Card No. :
First Name	:	
Address	:	
Tel. No.	:	Fax. No. :
D.O.B. / Age	:	Email :

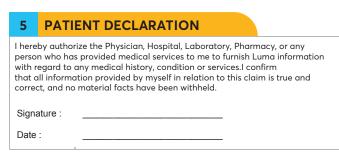
2 TRE	ATING FACILITY INFORMATION	
	TREATING MEDICAL OFFICER / REFERRING DOCTOR	HOSPITAL / MEDICAL FACILITY
Name	:	Name :
Tel. No	:	Tel. No :
Fax. No	:	Fax. No :
Email	:	Email :
Address	:	Address :

3 MEDICAL INFORMATION (to be completed by the Physician)

Present symptoms	:
Date when symptoms first occured	:
Has this or any similar condition existed previously?	 ☐ Yes ☐ If yes, please provide details / dates* :
Diagnostics / Investigations	:
Treatments / Medications	:
Provisional diagnosis	:

*Please continue on a blank sheet if more space required

4 PH	SICIAN DECLA	RATION	
his/her injur	ify that I have personall es/illness described abo y medical opinion of his/	, ve and that the facts :	
Signature : Date :			Stamp



 Hospital Contact (24/7)

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 Cambodia
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