PACIS
INSURANCE COMPANY LTD

Centenary House, 2nd Floor, Off Ring Road, Westlands,
P.O. Box 1870 - 00200, NAIROBI,
Tel: 254 - 20 - 4452560, Fax: 254 - 20 - 4452561,
Email:medical@paciskenya.com,
website:www.paciskenya.com

HOSPITAL PRE - AUTHORIZATION REQUEST FORM

1. This form duly completed should be sent to Pacis Insurance within 24 hours of admission of one of its members to hospital.
2. To avoid delays in authorization for admission, and/or payment of bills/invoices, answer ALL questions **COMPLETELY.**

To be completed by the patient

Name of insured Scheme/Company _____

Name of member _____ Member No. _____

Name of patient _____ Gender M ☐ F ☐

Date of birth _____ Date of admission _____

Name of hospital _____ Hospital admission No.: _____

To be completed by attending doctor

Present complaints _____

Cause of illness or accident _____

Is the condition congenital or recurring? Yes ☐ No ☐

Expected date of discharge _____

Provisional diagnosis _____

Clinical code _____ Procedure code _____

Name of admitting doctor _____ Telephone _____

Name of surgeon _____ Telephone _____

Name of anaesthetist _____ Telephone _____

Type of admission (tick one)	Please comment	Please fill in your charges
Emergency		Physician
Planned		Surgeon
Day Surgery		Anaesthesist

PATIENT

I ..... do hereby authorize any doctor, hospital, clinic or medical provider, any other company, institution or person who has record or information about me and / or my family members to provide my insurer with complete information including copies of their records with reference to my sickness or accident any treatment, examination, advice or hospitalization. Any photocopy of this authorization shall be taken as the original copy.

Patient/Parent/Guardian's Signature:..... Date:.....

DOCTOR

I hereby confirm that the information provided above is correct and true to the best of my knowledge.

Name: ..... Date: ..... Signature: .....

OFFICIAL USE ONLY

☐ **APPROVED** ☐ **NOT APPROVED** ☐ **FORM INCOMPLETE**

For Pacis use only	
Approved for Hospital	K. Shs.
Approved for Doctors	K. Shs.
Approved for Bed Type	
Patient must produce their NHIF card before discharge if a contributor	

Name: ..... Date: ..... Signature: .....

A member of AKI

For Comfort & Peace in Life