BankMED Namibia
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PRE-AUTHORISATION FORM FOR HOSPITALISATION

1. PARTICULARS OF PATIENT

Surname: **Initials:**

First Name:

Postal Address:

Date of Birth: **Sex:** Male Female **Relationship to Principal Member:** _____

Telephone No: **Fax No.:**

Medical Aid Membership No:

2. PARTICULARS OF PRINCIPAL MEMBER

Surname: **Initials:**

First Name: **Date of Birth:**

3. PARTICULARS OF MEDICAL PRACTITIONER

Surname: **Initials:**

Practice No.:

Postal Address:

Telephone No: **Fax No.:**

4. PARTICULARS OF HOSPITAL

Name: **Initials:**

Practice No.:

Contact Person: _____

Postal Address:

Telephone No: **Fax No.:**

5. PATIENT DETAILS

Medical Diagnosis: _____ **/Comorbidities** _____

Planned Procedure: _____

Admission Date: **Admission Time:** _____ **Estimated Days:** _____ **Estimated Cost:** _____

6. REGISTRATION (For Official Use Only)

Confirmation No.: _____

Signature: _____

Date: _____

Time: _____

Comments: _____

_____