



Medical Claim / Pre-Authorization Form

Complete all sections. Use one form per member per visit.

I. A. Patient Information (To be completed by member/patient/guardian)

Patient Name	
Date of Birth	
Employee Name	
Relationship to Employee	
Company / Employer	
Membership No.	
Telephone	
Email	

Declaration: I declare that the information provided is accurate and authorize Sahan Insurance to request relevant medical information. I understand that misrepresentation or omission may result in claim denial or recovery of costs.

Member / Guardian Signature: _____ Date: ___ / ___ / ___

2. B. Clinical Information (To be completed by attending physician/consultant)

Hospital Name	
Tel & Fax	
Diagnosis	
Brief History & Findings	

Pre-Authorization Request (select applicable):

- Emergency In-Patient
- Non-Emergency In-Patient
- Dental
- Optical
- MRI (IP/OP)
- CT Scan (IP/OP)
- Other

Admission Date	
Length of Stay	
Estimated Cost (USD)	

Doctor's Name: _____ Tel: _____

Confirmation: I confirm that the above information is true and accurate.

Doctor's Signature & Stamp: _____ Date: ___ / ___ / ___