Advance Request Form

Please complete this form and submit it to provider.uae@hayah-april.com within the timeframe defined in your policy Terms and Conditions.

☐ Pre-authorisation ☐ Letter of Guarantee ☐ Other (additional details below)

SECTION A (To be completed by the member)

Policy/Member Information

Patient Name:		Policyholder Name:
Policy Number:		Member Number:
Telephone:	Fax:	Email:

SECTION B (To be answered by member or parent, if patient is a minor)

If this claim pertains to illness

When and how did this illness first occur? When did you first consult a doctor about this problem or these symptoms?

Have you ever had a similar illness or similar symptoms? ☐ Yes ☐ No

Do you have other insurance which may cover this condition/treatment? ☐ Yes ☐ No

If you answer yes to either question, please give full details below and forward a copy of the policy where there is other insurance cover.

If this claim pertains to an injury:

Briefly describe how this injury occurred (include date, time and exact place):

Did this accident arise from your employment duties? ☐ Yes ☐ No
Was a third party involved? ☐ Yes ☐ No

If you answer yes to either question, please provide additional details below and state whether compensation will be provided.

Space for additional details:

Declaration

I hereby declare that all information provided on this form together with any documents submitted herewith are true and correct to the best of my knowledge and belief.

I acknowledge that, unless otherwise agreed by the Insurer ("the Company") in writing, a letter of guarantee or pre-authorisation of direct billing is not a confirmation of coverage for the condition or services, and that I remain responsible for charges not covered under the terms of the policy. If the Company guarantees and/or pays non-covered charges, I agree to reimburse the Company within 30 days after being notified of such non-covered charges.

Authorisation for Release of Information

I authorise any doctor, hospital, or other health provider or facility, insuring or reinsuring company, or employer to release to the Company any information or records they may have regarding my health, tests or treatments I have received, and benefits or compensation therefore. If this claim relates to an accident, past or present, I also authorise any governmental body, agency, or other person or organisation who may have records pertaining to such accident to release such records or information. I understand that this information will be used by the Company to determine eligibility for benefits, and that any information obtained will not be released by the Company to any person except to reinsuring companies or other persons or organisation(s) performing business or legal services in connection with my claim, save as may be required by law. I agree that a photocopy or facsimile of this release shall be as effective as the original.

Signature of Member (Parent if minor) _____ Date (DDMMYY) _____

SECTION C (To be answered by the attending physician)

Patient Name:		Policy/Member Number:	

Reason for hospitalization/procedure (symptoms and diagnosis/differential diagnosis). Please include ICD diagnosis code:		
Date the patient first consulted you about this condition or symptoms:		Date symptoms arose:
Are you the first medical practitioner the patient has seen about this condition or symptoms? ☐ Yes ☐ No (explain)		
Is this the first time the patient has experienced these symptoms or suffered from this condition? ☐ Yes ☐ No (explain)		
Brief summary of treatment plan including procedure(s) (if any):		
What tests or procedures have been done prior to this hospitalisation (attach results if applicable):		
Is any part of this claim related to the treatment of birth defects, congenital or hereditary conditions, behavioural / psychological / mental / nervous disorders, fertility assisted conception, contraception, sexually transmitted disease or cosmetic treatment? ☐ Yes (explain) ☐ No		
Hospital Name		
Planned Admission Date:		Estimated Length of Stay:
Please provide full breakdown of estimated costs (please indicate currency):	Professional Fee:	
	Other Charges:	
	Hospital:	

Attending Physician Name:		
Address:		
Tel:	Fax:	Email:

Physician's Signature

Date (DDMMYYYY)

Official Stamp

Please send completed form to **provider.uae@hayah-april.com**

2025/04