PRE-ADMISSION FORM FOR LOG

Please furnish the following information/documents to Ulink Assist:

i. Please fully complete all sections in order for us to process pre-admission letter of guarantee
ii. Relevant medical documents
iii. Estimated length of stay and estimated cost from hospital
iv. Please submit a new form for each separate visit, illness or injury
v. Incomplete information and medical documents may result in rejection or delay of LOG process

PART (1) - TO BE COMPLETED BY INSURED OR POLICY OWNER

Section A: Patient Information

Name of Patient	
Policy Number	
NRC	
Date of Birth	
Admission date	
Hospital Name	
Doctor Name	
Room type/ Ward type	

Section B: Contact details

Email	
Contact Number	

Section C: Declaration, Consent and Authorisation by insured or policy owner

By completing the form, I hereby declare that:

(a) I am the patient, or the patient's parent or guardian if the patient is under 18 years of age.

(b) All information on this pre-admission form is true and correct based on the best of my knowledge.

(c) I authorize my treating doctor(s), clinic, hospital or any other medical provider to provide access and furnish all necessary and relevant reports and/or medical and invoice information pertaining to my personal data and medical condition (these may include information regarding past medical history, psychological notes, drug or alcohol abuse notes, AIDS and other sexually transmitted disease related information) to ULINK ASSIST COMPANY LIMITED, including its associate companies, partners and affiliates, as may be required.

(d) I further authorise ULINK ASSIST COMPANY LIMITED, including its associate companies, partners and affiliates to have access, to use, to receive and to share for valid purpose such reports and/or information obtained from myself, authorised representatives, treating doctor(s), clinic, hospital or any other medical provider for the purpose of evaluating and providing my medical care, assistance services or healthcare benefits administration services, as well as to coordinate, assess and determine my entitlements, benefits and/or reimbursements in connection with my health or medical insurance coverage.

(e) I acknowledge that the information submitted herein shall be used only for the pre-authorisation of direct settlement by ULINK ASSIST COMPANY LIMITED with the clinics/hospitals for any eligible and approved charges relating to my approved medical treatment. I agree to pay any excess amounts and uncovered medical expenses (if any) to clinics/hospitals or ULINK ASSIST COMPANY LIMITED within 7 business days from date of request. The actual covered amount is subject approved based on the information provided in the pre-admission form, actual diagnosis, eligible policy benefit, exclusion clause, terms and conditions stated in the policy document.

Signature		**Date of consent**	
Insured name		**Relationship to patient (if applicable)***	

*If this authorisation is being signed by a personal representative on behalf of the patient

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Ulink Assist

PART (2) - TO BE COMPLETED BY ATTENDING DOCTOR

Section A: Medical details

a) Diagnosis / Provisional Diagnosis

b) Is the condition and treatment related to the following:

- ☐ Pregnancy / Childbirth / Infertility / Miscarriage Or any complications arising therefrom
- ☐ Congenital / Hereditary disease
- ☐ Drugs / Alcohol abuse
- ☐ Mental / Psychiatric disorder
- ☐ Cosmetic reason / Dental care / Refractive errors correction
- ☐ STD / AIDS/ HIV related
- ☐ None of the above

c) Details of the symptoms and condition

Date of first consultation
Estimated date of onset of symptoms / Duration of symptoms
Description of symptoms

d) Can the condition be managed under Outpatient basis?

☐ YES ☐ NO

If YES, please provide reason for this hospitalization

e) Any previous consultation / treatment / hospitalization for this symptom / illness or related conditions, or other disorders whether in this hospital or any other facilities prior to current admission?

☐ YES ☐ NO

If YES, please send previous hospitalisation and medical reports.

f) Name of surgery or procedure (if applicable)

Attach medical reports and investigation results

g) Estimated length of stay in hospital

h) Estimated hospital cost

Attach cost estimated form from hospital if any

i) If hospitalization was due to injury, please indicate date/ time of accident and describe circumstances and cause of injury

Date / time of accident:

j) Additional attachment if any (E.g. Relevant Medical Record, Referral Letter, Police report for accident, biopsy report)

Section B: Declaration, Consent and Authorisation by attending doctor

By completing the form, I hereby declare that:

(a) I have personally examined and treated the Insured (i.e. patient) in respect of the medical condition described above and that the information stated above represent my genuine and honest opinion of his/her condition and my recommended treatment; and

(b) All information on this pre-admission form is true and correct based on the best of my knowledge.

(c) I authorize (name of insurer) to release this medical information (these may include information regarding past medical history, psychological notes, drug or alcohol abuse notes, AIDS and other sexually transmitted disease related information) to ULINK ASSIST COMPANY LIMITED, including its associate companies, partners and affiliates, as may be required.

Doctor`s Name		**Doctor`s Signature**	
Medical License No. (or) Stamp of Doctor		**Date of declaration**	