MSH CHINA

MSH CHINA ENTERPRISE SERVICES CO.,LT/万欣和(上海) 企业服务有限公司

Return Fax Number/传真: 86-21-6160-0209 **E-Mail: medical@mshchina.com**

Note: Please submit any supporting medical documentation along with this completed Pre-authorization Form. （备注：请将所有相关的医学资料与填写完整的事先授权表一起递交）

Pre-Authorization Request For Medical Treatment（事先授权表）

Provider Contact Name (联系人姓名):_______________ Fax #(传真):_____________________

Phone #(电话): ___________________________ E-mail(邮件地址): ____________________

Name of Facility(医院名称): ____

Address of Facility(医院地址): _________________________ Country(国家):_______________

Name of Attending Physician(主治医生): ____

The following must be filled out by the provider of service(以下各项须由医生填写):

Name of Patient(病人姓名): ____

Date of Birth (出生日期)____

Policy Number(保险号码):____

Patient's Phone #(电话):____

Caused by(导致原因):

Check One(选择其一): Accident (事故) _______ Illness(疾病) _______ Delivery (生育) _______

Date of Invasion at this time(本次发病时间): ____

Physical Exam Result(体格检查结果): ____

Lab Test Results(实验室检查结果): ____

Related Illness History(相关疾病过去史): ____

Medical Diagnosis(医疗诊断): ____

Failed Conservative Medical Management (经历的未成功的保守治疗方案):

____

____

Procedure(步骤):

Check One(选择其一):

Outpatient (门诊) ______

Expected Procedure(预计治疗 / 检查 / 门诊手术): _____________________________________

Expected Date of Procedure(预计日期): ____

Inpatient(住院) _______

Expected Procedure(预计治疗 / 检查 / 住院手术 / 生育): ________________________________

Expected Length of Stay(预计住院总天数): ____

Date of Operation(手术日期): ____

Name of Operation(手术名称): ____

Days of Pre-operation(术前时间): __________ Days of Post-operation (术后时间): ____________

Estimated Cost(估计费用): US$ _________________________/ RMB _____________________

Method of Anesthesia(麻醉方式): ____

If Assistant Surgeon is needed, please provide notes explaining medical necessity(如还需别科（院）医生会诊，联合手术，请阐释医学必要性):

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Additional Comments(备注):

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Failure to complete and submit this form could result in substantial penalties for the client (如果没有填写事先授权表或者重要信息缺失,可能给客户造成不必要的损失).