Jubilee
INSURANCE

HOSPITALIZATION PRE-AUTHORIZATION FORM

The Jubilee Insurance Company of Kenya Limited
Head Office:
Jubilee Insurance House, Wabera Street,
P.O. Box 30376 - 00100 GPO, Nairobi, Kenya
Tel: +254 709 949 000, +254 20 3281000
Email: medicalcaremanagers@jubileekenya.com,
callcenter@jubileekenya.com
www.jubileeinsurance.com

Mombasa:
Jubilee Insurance Building, Moi Avenue,
Email: mombasa@jubileekenya.com

Kisumu:
Jubilee Insurance House, Oginga Odinga Road,
Email: kisumu@jubileekenya.com

DIRECTIONS:
Please read carefully and fill out the entire form.
1. *Answer all questions otherwise there may be delays in preauthorization of the admission and/or bills/invoices may not be paid. (Complete in CAPITAL Letters).*
2. *A duly completed and signed inpatient form should be sent to Jubilee insurance within 24hrs of admission of one of its members to your hospital.*
3. *All FIELDS MUST be completed to avoid delay or rejection of the authorization.*

TO BE FILLED BY THE INSURED/PATIENT

Patient Name

Gender: ☐ Male ☐ Female Age: Years _____ Months _____

Date of birth day/month/year Mobile No. Member number

Scheme

Name of employee

Relation to insured ☐ Self ☐ Spouse ☐ Child

TO BE FILLED BY THE TREATING DOCTOR/HOSPITAL

Name of hospital

Date of admission day/month/year Time

Is it an emergency /a planned hospitalization event? ☐ Emergency ☐ Planned ☐ Day Case

Presenting complaints

Relevant clinical findings

Duration of the present ailment _____

Provisional diagnosis

Past history of present ailment if any

Date of diagnosis

Proposed line of treatment:
☐ Medical management ☐ Surgical management ☐ Intensive care ☐ Investigative care

If investigation/medical management provide details

If surgical, name of surgery: _____

If other treatments provide details:

_____

In case of accident/injury:
Is it RTA ☐ Yes ☐ No Details of injury? _____

Date of Injury day/month/year

Injury/Disease caused due to substance abuse/Alcohol consumption ☐ Yes ☐ No
Attach copy of test conducted to rule out the report

In case of **maternity** ☐ G ☐ P ☐ L ☐ A ☐ EDD _____ Length of stay _____ (Days)

Mandatory: Present/Past history of any chronic illness if yes, since (month/year)

- ☐ Diabetes
- ☐ Heart disease
- ☐ Hypertension
- ☐ Hyperlipidemias
- ☐ Osteoarthritis
- ☐ Asthma/COPD/Bronchitis/TB
- ☐ Cancer/Tumor/Cyst
- ☐ Alcohol/Drug abuse
- ☐ HIV/Immuno suppression
- ☐ Thyroid disease
- ☐ Congenital/Recurrent
- ☐ Psychiatric condition
- ☐ Paralysis/CVA/Epilepsy

Any other ailment, give details: _____

Specialty	Name of the Doctor	Charges
Physician		
Surgeon		
Anesthetist		

Estimated cost of treatment: _____

PATIENT'S DECLARATION

1. I hereby authorise the hospital/physician to submit all the details and original documents requested for and pertaining to hospitalization to The Jubilee Insurance Company of Kenya Limited.
2. Payment to the hospital is governed by the terms and conditions of the policy. In case Jubilee Insurance is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.
3. I hereby confirm that the information provided is accurate and correct to the best of my knowledge and I am aware that any fraudulant, false, intentionally exaggerated or unfounded, suppressed information provided in respect to the claim, may cause the claim to be forfeited and not payable/recoverable by Jubilee Insurance.

Patient's/Insured's name: _____ Patient's /Insured's signature: _____

DOCTOR'S DECLARATION

1. We have no objection to any authorized Jubilee Insurance official verifying documents pertaining to hospitalization.
2. We agree that Jubilee Insurance will not be liable to make payment in the event of any discrepancy between the information provided in this form and the discharge summary or other relevant documents.
3. We agree to provide clarifications for the queries raised regarding this hospitalization. In addition, medical reports will be provided within 24 hrs upon request.

Doctor's name: _____ Doctor's signature: _____

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

1. Detailed discharge summary and all bills from the hospital.
2. Radiological test report from Radiologists and Surgeon's report and bills.