

PRE-CERTIFICATION FORM

Please note the following:

- All details in this form are to be duly completed and signed by both the doctor and the insured member.
- Please provide these documents for admission to:
 - A) Private Hospital**
Page 1 & 2 of this form (Page 2 to be completed by the Attending Doctor/Surgeon) & any lab test result(s).
 - B) Singapore Restructured Hospital:**
Page 1 of this form, Hospital Financial Counselling/Admission Forms & any lab test result(s).
- Any missing information or documents may delay the issuance of the Letter of Guarantee (LOG).
- Prior to admission, please email this form together with the above supporting documents to aoncare@fullertonhealth.com
- Following your discharge from the hospital, if you are also claiming against a Medisave-approved Integrated Shield Plan or any other third party insurer for the admission, please submit a copy of the other insurer's settlement letter through the Aon Care Portal.

A) Details of Insured Member

Company Name		
Employee Name	Employee NRIC / FIN No.	Contact No.
<i>Below to be completed if Patient is not the Employee</i>		
Patient Name	Patient NRIC / FIN No.	Relationship to Employee

B) Declaration of Insured Member

- Is your condition / injury arising from workplace or during course of work? ☐ NO ☐ YES
- Are you claiming from Work Injury Compensation Insurance for this surgery / admission? ☐ NO ☐ YES

C) Consent & Authorisation of Insured Member

- I hereby authorise, agree and consent to:
 - Insurer and Fullerton Healthcare Group to request from any hospital, physician, person or organisation, all information with respect to any illness, injury, medical history, and copies of all hospital or medical records concerning myself or dependents at any time and authorise the prior mentioned organisations to disclose all such information to Insurer and Fullerton Healthcare Group.
 - Insurer and Fullerton Healthcare Group collecting, using, and/or disclosing my personal data for the processing of pre-certification and such other purposes ancillary or related to the administering of my insurance coverage and claims adjudication.
- I agree that Insurer and Fullerton Healthcare Group and my Employer reserve the right to recover any outstanding amount from me should my total medical expenses exceed the policy coverage and/or is not covered under the policy.
- I hereby declare that all the information, above statements and answers including any attachments related to it are true and complete. I have not withheld any material fact from Insurer, Fullerton Healthcare Group Pte Limited and my Employer.
- I agree that a photocopy of this authorisation shall be considered as effective and valid as the original.

Insured Member's Signature: _____

Date: _____

Disclaimer

Aon Care is a medical network administering insurance policies arranged by Aon Singapore Pte. Ltd ("Aon") acting as an insurance broker. Aon is not an insurer and does not guarantee the acceptance, application or availability of insurance. The content of this form has been compiled by Fullerton Healthcare Group Pte Ltd and is subject to the terms, conditions and exclusions of the regulated insurer's policy wording which may change from time to time. Refer to the relevant policy document for complete and most up to date details. Neither Aon, nor any Aon Group entity, will be held liable for the contents of this form, its existence or any representations made in its connection. For further information on Aon Care or related insurance products, please contact a representative of Aon.

D) For Admission to Private Hospitals (Member to arrange for completion by the Attending Doctor / Surgeon)

1. Particulars of Attending Doctor/Surgeon

Doctor / Surgeon: _____

Referring Doctor: _____

Clinic Name: _____

Clinic Address: _____

2. Condition Requiring Treatment

Symptoms: _____

Date when symptoms 1st presented: _____

Diagnosis: _____

Date when condition was diagnosed: _____

ICD 10 Code: _____

First Consultation Date: _____

a) Has this or any similar condition existed previously?

☐ NO

☐ YES

If yes, please state the date of treatment, name and address of doctor who treated the patient

3. Is the condition of patient due to or related to:

a) Congenital anomaly ☐ NO ☐ YES

b) Cosmetic or plastic surgery ☐ NO ☐ YES

c) Psychological, mental or emotional disorder ☐ NO ☐ YES

d) Dental/gum treatment or oral mucosal ☐ NO ☐ YES

e) Pregnancy, childbirth, sub-fertility or infertility (Date of last menstruation _____) ☐ NO ☐ YES

4. Is patient's condition / injury due to an accidental event?

☐ NO ☐ YES

If 'Yes' to above, please advise whether it is work-related

☐ NO ☐ YES

5. Details of Surgery / Procedure

Hospital Name: _____ Admission Date: _____

Admitted as: ☐ DAY SURGERY ☐ IN-PATIENT (Estimated Length of Stay: _____)

Are the surgical procedures listed below to be performed through the same incision / orifice? ☐ NO ☐ YES

6. Estimated Cost of Admission:

*Please list down below all the surgical procedures with breakdown of individual charges if more than one will be performed:

Estimated Cost

(Exclude GST): Required Information (please provide in separate sheet if space is insufficient):

*Surgeon Fee : _____ Surgical Procedure: _____ Surgical Code: _____

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Dr's Attendance Fees : _____ Rate SGD _____ /day X No. of Days: _____

Room & Board : _____ Rate SGD _____ /day X No. of Days: _____

Anaesthetist's Fees : _____

Hospital Charges : _____

Clinic Consumables : _____ Breakdown of Charges: _____

Implant(s) Cost : _____ Breakdown of Charges: _____

Total Estimated Cost : _____

7. Doctor / Surgeon's Signature: _____

Date: _____