UCAF 2.0

To be completed & ID verified by the reception/nurse:

Provider Name: ....

Insurance Company Name: .... TPA Company Name: ----------------

Patient File Number: .... Dept: ....

Single ( )   Married ( )   Plan Type ( )

Date of visit ___/___/___

New visit ( ) | Follow Up ( ) | Refill ( ) | Walk In ( ) | Referral ( )

Print/Fill in clear letters or Emboss Card:

Insured Name ....

ID. Card No. .... Sex .... Age ......Y

Policy Holder .... Policy No ....

Expiry Date _____/___/_____ Class ....

Approval ....

To be Completed by the Attending PHYSICIAN: Please tick (✓)

Inpatient ( )   Outpatient ( )   (Emergency Case ( ) | Emergency Care Level : 1 ( )   2 ( )   3 ( ))

BP: ___/___   Pulse: ____ bpm   Temp: ____°C   Weight: ____Kg   Height: ____cm   R.R: _____   Duration of Illness: _____ (Days)

Chief Complaints and Main Symptoms ....
....

Significant Signs: ....

Other Conditions ....

Diagnosis ....

Principal Code: .... 2nd Code: .... 3rd Code: .... 4th Code: ....

Please tick (✓) where appropriate:

Chronic ( )   Congenital ( )   RTA ( )   Work Related ( )   Vaccination ( )   Check-Up ( )

Psychiatric ( )   Infertility ( )   Pregnancy ( )   Indicate LMP: ....

Suggestive line(s) of managmenet: Kindly, enumerate the recommended investigations, and/or procedures **For outpatient approvals only:**

Code	Description/Service	Type	Quantity	Cost

Providers Approval/Coding Staff must review/code the recommended service(s) and allocate cost and complete the following:

Completed/Coded By _____ Signture _____ Date _____/___/_____

Medication Name (Generic Name)	Type	Quantity

In Case managment Form (CMF1.0) included   **Yes ( )   No ( )**

Please specify possible line of management when applicable: ....

Estimated Length of stay: .... days   **Expected date of admission:** _____/___/____

I hereby certify that ALL information mentioned are correct and that the medical services shown on this form were medically indicated and necessary for the management of this case.

Physician   Signture   Stamp   Date

_____ _____ ◯ _____/___/___

I hereby certify that ALL statements and information provided concerning patient identification and the present illness or injury are TRUE.

Name (and relationship (if guardian): ----------------------

Signture (*) .... Date _____/___/___

For Insurance Company Use Only: Approved ( )   Not Approved ( )   Approval No: ....   Approval validity: ....Days

Comments (include approved days/services if different from the requested) ....

Approved /Disapproved By _____ Signature _____ Date _____/___/___

(*) This is applicable only in case of manual UCAF