مجلس الضمان الصحي
Council of Health Insurance

ملحق رقم (1)

نموذج طلب الموافقات والمطالبات الموحد

UCAF

ملحق رقم (1): نموذج طلب الموافقات والمطالبات الموحد

Appendix no. (1): UCAF

إشارةً إلى الملحق رقم (2) من اللائحة التنفيذية لنظام الضمان الصحي التعاوني لمعايير طلب الموافقة على تحمل تكاليف العلاج، التي أوضحت الإجراءات المتبعة في حال طلب الموافقة من قبل المرافق الصحية ومسئوليات شركات التأمين للالتزام بما ورد فيها. النموذج الموحد يجب أن يتضمن جميع المعلومات الأساسية المذكورة فيه وأن يتم الالتزام بمعايير الترميز المعتمدة من المجلس وأن تكون الخدمات حسب قوائم الأسعار المتفق عليها حسب النموذج رقم (6). هذا النموذج يجب أن يكون جزء من متطلبات المطالبة التي ترسل من قبل المرفق الصحي إلى شركة التأمين.	Referring to Appendix No. (2) of the executive regulations of CCHI for the criteria of requesting approval to bear the costs of treatment, which clarified the procedures followed in the event that approval is requested by healthcare providers and the responsibilities of insurance companies to comply with what is stated therein. The unified form must include all the basic information mentioned in it, the coding standards approved by the council must be adhered, and the services must be according to the price lists agreed upon according to form No. (6) in this contract. This form should be part of the claim requirements that are sent by the healthcare providers to the insurance company.

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 ( )

Data of visit / /

New visit ( ) I Follow Up ( ) I Refill ( ) I walk in ( ) I Referral ( )

Print/Fill in clear letters or Emboss Card:

Insured Name: .....

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

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

Expiry Data / /

Approval .....

To be completed & by the Attending PHYSICAIN: Please tick (✓)

Inpatient ( ) Outpatient ( ) **Emergency Case ( ) I 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 ( )

Suggestive line(s) of management: 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 **Signature** **Data / /**

Medication Name (Generic Name)	Type	Quantity

I Case management Form (CMF 1.0) included Yes ( ) No ( )

Please specify possible line of management when applicable:

Estimated Length of stay days **Expected date of admissions: / /**

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 Signature Stamp Date / /

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

Name and relationship (if guardian):

Signature (*) Data / /

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** **Data / /**

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