PRE – AUTHORIZATION REQUEST FORM	
NAME OF PATIENT:	
MEMBER ID:	
DETAILS OF MEDICAL CONDITION & DIAGNOSIS:	
DETAILS OF PROPOSED TREATMENT REQUIRED / DIAGNOSTIC PROCEDURE / SURGERY :	
DOCTORS SIGNATURE: DATE:	
ESTIMATED COST:	
ROOM + NURSING CHARGES	
DOCTOR'S / SURGEON'S CHARGES	
SURGERY	
OT & ANAESTHESIA	
LABORATORY / RADIOLOGY CHARGES	
PHARMACEUTICALS	
OTHERS	
APPROXIMATE TOTAL AMOUNT	

FOR PENTACARE USE ONLY

a.) FURTHER INFORMATION REQUIRED:

b.) APPROVED:

Kindly fill this form & fax it to Pentacare, Fax No. 04-2946448 / Helpline No (24/7): 800(73682)

Tel: 04-2946443 P.O. Box 185408 Dubai. info@pentacare.net