Global healthcare

Date of request:

Patient's name:

Patient's date of birth:

Patient's Policy number:

Pre-approval Request Form

Provider name:

Contact details:

Please confirm cover for the following:

Treatment:

Diagnosis:

Admission date:

Discharge date:

Estimated cost:

☐ **I confirm that I have the patient's consent to share relevant medical information about this condition, with AXA and associated parties, for the purpose of assessing and processing the patient's claim.**

E-mail your completed Pre-approval Confirmation Request form to ICMTmed.health@axa.com. You will hear back from us within 48 hours.

If medical treatment is urgent or taking place within the next 48 hours please call us on +44 (0)1892 503856. When you call please ensure that you have all the above information ready and have obtained the patient's consent.