CG | INSURANCE

LETTER OF OVERSEAS REFERRAL/ PRE-CERTIFICATION REQUEST

Premier Health

PART 1 APPLICANT/DIAGNOSIS DETAILS

Patient Name: ____________________ Date of Birth: ____________

Name of Insured: ____________________

Address: ____________________

Email: ____________________ Phone No.: ____________

Employer: ____________________

Group Name: ____________________ Policy/Certificate No.: ____________

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child

General Practitioner (family physician): ____________ Contact No.(s): ____________

Referring specialist: ____________ Contact No.(s): ____________

Medical Diagnosis (Please include ICD-9 codes if possible): ____________________

____________________ Date of onset of symptoms: ____________

Relevant history for the current medical diagnosis: ____________________

____

____

Medical/surgical treatment for which the patient is being referred (please include CPT codes if possible): ____________

____

____

Is this treatment/procedure/consult available in Turks and Caicos .... ☐ Yes ☐ No

Is the accepting physician/facility a network provider? .... ☐ Yes ☐ No

Referral primarily initiated by (please check one): .... ☐ Physician ☐ Patient/Family

Details of the physician to whom your patient is being referred:

Name: ____________________

Address: ____________________

Contact No.(s): ____________ Fax No.: ____________ Appointment Date: ____________

Details of the facility where your patient is being referred:

Name and Department: ____________________

Address: ____________________

Contact No.(s): ____________ Fax No.: ____________

Is the physician and/or facility known to you? .... ☐ Yes ☐ No

If No, why has it been chosen? ☐ Patient's choice ☐ Other: ____________

Is it expected that subsequent medical/surgical care can be rendered locally? .... ☐ Yes ☐ No

If so, by whom? ____________________

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PART 2 OVERSEAS REFERRAL REQUEST: If the patient requires transfer overseas, complete this section.

Date of admission to hospital/clinic?__________________ Location/Department: ______________________________________

Insurance company notified of potential transfer on: ....Date:__________________________ ☐ No

The patient is fit to travel by commercial airline .... ☐ Yes ☐ No

The patient requires air ambulance evacuation .... ☐ Yes ☐ No

The patient requires accompaniment by an ACLS registered nurse*.. ☐ Yes ☐ No

The patient does not require the accompaniment of an RN, but accompaniment of family member or friend is medically necessary .... ☐ Yes ☐ No

If Yes, please explain why?______________________________________

Oxygen is needed on board.. ☐ Yes ☐ No

Wheelchair assistance is required .... ☐ Yes ☐ No

Other special equipment is needed on board .... ☐ Yes ☐ No

If Yes, please detail: ______________________________________

Medical need for a first class or bulkhead seat.. ☐ Yes ☐ No

If Yes, why? ______________________________________

Mode of transportation required at destination ______________________________________

*Note: The previous medical history must substantiate necessity and clinical data may be required.

PART 3 PHYSICIAN'S STATEMENT FOR AIRLINES/CUSTOMS

All reasonable medical precautions have been undertaken to ensure that the named patient is fit to fly by commercial airline with the above provisions. Nurses accompanying the patient have medical authorization to carry prescription drugs, including narcotics.

Physician's Signature:______________________________________ Date: ____________________

I understand that should subsequent overseas travel be required, including follow up visits, the respective insurance company requires documentation of medical necessity prior to the patient's departure.

Physician's Signature:______________________________________ Date: ____________________

PART 4 INSURED'S DECLARATION

I hereby authorize my physician/hospital to give my insurance company/third party payer or their managed care representative any pertinent medical information regarding myself/my dependent child in connection with medical claims incurred in conjunction with this referral. I agree that a faxed copy of this release is acceptable to me.

Signature of Insured: ______________________________________ Date: ____________________

PART 5 SERVICES THAT REQUIRE PRE CERTIFICATION/MEDICAL REFERRAL

The following items require pre certification or medical referral for the insured's healthcare plan:

- MRIs
- Sonograms
- CT Scans
- Surgery (in patient and out patient)
- Maternity Expenses
- Air Ambulance
- Air Transportation
- Transplant Procedures
- All In patient and out patient chemotherapy and radiation services

Non-certification penalty:

- 50% penalty for Off-Island/Out of Network services
- 25% penalty for On Island/In Network services

Coralisle Insurance Brokers (TCI) Ltd. Regent Village West, Units J102-J104, Ventura Drive, Grace Bay, Providenciales TKCA 1ZZ
Turks and Caicos Islands | Tel 649 941 3195 | Fax 649 941 3197 | www.CGCoralisle.com

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