PRECERTIFICATION AND DIRECT PAYMENT REQUEST

MSH INTERNATIONAL 2020

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IMPORTANT NOTE

- Please fill out the whole document and send it back to MSH INTERNATIONAL at least 10 days before the service date.
- **Mandatory fields are marked with the * symbol. Please make sure to complete them.**
- **An incomplete application will delay the processing of your precertification request or may prevent us from issuing a letter of guarantee.**

SECTION A: GENERAL INFORMATION

MAIN INSURED

*First Name ______ *Last Name ______ *ID Number ______

Phone Number ______ Fax ______ Email Address ______

*PATIENT (if different from the Primary Insured)

*First Name ______ *Last Name (Maiden name if applicable) ______ *Date of Birth (MM/DD/YYYY) ______

☐ Male ☐ Female ☐ Non-binary ☐ Undisclosed

Phone Number ______ Fax ______ Email Address ______

*Please also include the following supporting documentation:

Specialist Consultation

- Referral letter from GP to specialist *(must include a brief summary of symptoms, suspected diagnosis and date referral letter was sent).*
- Letter from Specialist confirming appointment date *(this date must be 45+ days from date of referral letter).*

Diagnostic Imaging

- Requisition form sent to Diagnostic Imaging Centre *(must include date).*
- Letter from Diagnostic Imaging Centre confirming appointment date *(this date must be 45+ days from date of requisition form).*

In-Patient or Out-patient Surgery

- Detailed medical report from Specialist including medical history, previous treatment, diagnosis and procedure to be performed.
- Letter from Hospital confirming the appointment date of the surgery. If this can't be obtained, a letter from the Specialist or Surgeon confirming the estimated wait time for the procedure.

SECTION B: TYPE OF PROCEDURE

*Diagnosis ______ *Treatment ______

☐ In-Patient Surgery ☐ Out-Patient Surgery ☐ Out-Patient Treatment or Exam ☐ Diagnostic Imaging ☐ Specialist Consultation

***Release of Medical Information:**

I, ________________________________ hereby give consent for all medical staff involved in my past or present treatment to release any relevant information to the medical department of MSH INTERNATIONAL.

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SECTION C: REFERRING PHYSICIAN'S INFORMATION

*Physician's Name

*Address	*City	*ZIP/Postal Code	*Country

*Phone	*Fax	Email Address

PRIVACY POLICY

Protecting Your Personal Information

At MSH INTERNATIONAL, we recognize and respect the importance of privacy. When you submit a precertification, the insurers establish a confidential file that is kept in the offices of the insurers or the offices of an organization authorized by the insurers. We limit access to information in your file to insurer staff and/or the insurers who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use this information for the purpose of assessing your precertification and administering the group benefits plan. Personal information is protected from unauthorized use and disclosure in accordance with the Freedom of Information and Protection of Privacy Act.