Health and Surgical Procedures
Pre-Authorization Form

Internacional de Seguros

Company with whom you have the Policy: _____

Policyholder's Name: _____

Email: _____ **Phone**: _____

Name of person receiving the service: _____ **Identification N°:** _____

Age: _____

Name of Treating Physician: _____ **Phone:** _____

Condition Information

Type of condition: Accident ☐ Illness ☐ Pregnancy ☐ Other ☐ Date of onset of illness/accident/pregnancy: _____

Service Requested: Medications ☐ Laboratories ☐ Imaging ☐ Procedures/Surgery ☐ Other _____

Diagnosis/Diagnostic Impression/Symptoms (Detail):

Detail previous treatments received for this condition:

Surgical Procedure

Proposed Clinic/Hospital: _____

Proposed Date: _____ Outpatient ☐ Inpatient ☐ Estimated days of hospitalization _____

Procedure	**CPT Code**

Fees

Surgeon: _____

Anesthesia: _____

Assistant: _____

Physician's Signature and Medical Code: _____ **Stamp:** _____ **Date:** _____

Policyholder: I authorize all physicians, hospitals and other institutions or persons who treated me for the disease described in this form to provide Aseguradora del Istmo (ADISA) S.A. with any information including exact copies of records, diagnostic tests and other relevant information.

Policyholder's Signature _____ **Date:** _____

The contractual documentation and the technical note that compose this product are registered before the General Insurance Superintendence in accordance with the provisions of Article 29, paragraph d) of the Insurance Market Regulatory Law No. 8653, under registration No. P20-64-A07-399, dated January 17, 2013.