William Russell

Pre-Authorisation of Treatment Form

Please complete this form in **BLOCK CAPITALS** using black ink, and return it to us by email or post. You can find our contact details at the end of this form.

Your personal details

First name: ..... Surname: ..... Title: .....

Address: .....

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Policy number: ..... Date of birth: .....

Email: ..... Telephone number: .....

Details of your regular physician

Name of physician: .....

Address: .....

.....

..... Email: .....

Telephone number: ..... Fax number: .....

Details of condition being treated

Please describe your symptoms: .....

.....

.....

When were you first aware of your symptoms? If you were not experiencing any symptoms, or if the condition was identified during a routine check-up, please indicate: .....

.....

When did you first consult a physician with regard to these symptoms? .....

What is your physician's diagnosis? .....

Do you have a proposed treatment plan or medical report? If yes, please email it to us. ◯ Yes ◯ No

Please state the name and contact details of the physician(s) you consulted (if not your regular physician): .....

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Clinical information

Have you ever suffered from this or any related condition before? ◯ Yes ◯ No

If **YES**, please provide details of the physician(s) you consulted about the condition(s). Please attach details of any investigations, medical reports and test results to date

Condition	Name and details of physician	Date last consulted	Investigations/treatment received

Declaration and authorisation

Do you have any other health insurance cover? ◯ Yes ◯ No

If YES, please state the insurance provider and your policy number: .....

Provider's email: ..... Provider's telephone: .....

Are you entitled to benefits under any state-funded medical care scheme, and/or do you hold a Global/European Health Insurance Card (i.e., GHIC or EHIC)? ◯ Yes ◯ No

I hereby declare that, to the best of my knowledge and belief, all information provided in this claim form is accurate and complete. I hereby authorise any physician, doctor of medicine, hospital or other person who has attended or examined me, to furnish to William Russell or to their authorised representative any and all information with respect to sickness or injury, medical history, consultation, prescriptions, or treatment and copies of all hospital or medical records relating to me (or to the patient if I am the patient's parent/legal guardian). I accept that my personal details may be passed to selected third parties, such as cost agents and third party administrators, for the sole purpose of assisting with the administration of my claim.

I hereby give William Russell authorisation to correspond with me by email regarding my claim. I understand that these emails may contain reference to my medical condition/s and financial payment information.

Name of claimant*: .....

Signature of claimant: ..... **Date:** .....

*This should be completed by the claimant's parent or guardian **if** the claimant is a child under age 16, or by the claimant's next of kin if the claimant is unable to provide properly informed consent due to cognitive disability or otherwise, or if the claimant is deceased. Please also state your relationship to the claimant and provide contact information.

Contact Details
T +44 1276 486 460
E claims@william-russell.com
william-russell.com

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