[redacted]

McGill

PRE-AUTHORIZATION REQUEST FOR HOSPITALIZATION/SURGERY

PO BOX 3300, STATION B, MONTREAL (QUEBEC) H3B 4Y5
FAX: 514-286-8480 (ATTENTION: CLAIMS DEPARTMENT)
E-MAIL: contact@medavie.bluecross.ca

TYPE OF HOSPITALIZATION/SURGERY

- ◯ Planned hospitalization and/or surgery
- ◯
- ◯

IDENTIFICATION

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Relationship to student: _____

Contract Number: _____ Group Number: _____

Date of Birth (MM/DD/YYYY): _____

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Diagnosis (including probablity/possibility of complications): _____

_____

_____

◯ No ◯ Yes

If “yes”, state when and describe: _____

_____

_____

Type of treatment: ◯ Surgery ◯ Therapy ◯ Other treatment plan

Describe the type of treatment and projected duration of treatment (if applicable):

_____

_____

_____

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67$7(0(17

3K\VLFLDQ·V QDPH 3ULQW _____

Address: _____

Permit Number: _____ Telephone Number: _____

Fax Number: _____

I hereby certify that, to the best of my knowledge, the statement made above is complete and true.

Signature: _____ Date: _____