

PRECERTIFICATION REQUEST FORM

A. Member Information

First Name:	Last Name:
Employer:	

Unimed Number:	
Date of Birth:	
Contact No.:	
Email:	

Patient Information (if different from above)

First Name:	Last Name:

Date of Birth:	
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Do you or the patient have any other medical coverage? ☐ Yes ☐ No

If "Yes" to the above give details:	
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B. Treatment Details

Diagnosis (if known):	
Procedure:	
Estimated Cost:	
Estimated date of treatment:	

Is this quotation being covered by any other health plan, government program or public assistance? ☐ Yes ☐ No

If "Yes" to the above give details:	
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C. Declaration & Authorization

I, the undersigned, hereby declare that the information provided in this form and accompanying quotation is true and complete to the best of my knowledge.

I authorize M&M Insurance Broking Services Limited to:

- Obtain any medical records, reports, or other relevant information from my healthcare provider(s) related to this request and share such information with its medical advisors, consultants, and other authorized third parties for the purpose of assessing this precertification request.

I, the undersigned, understand and agree:

- Precertification is not a guarantee of payment, and all claims remain subject to the terms, conditions, and exclusions of the health plan.
- All benefits not paid by M&M Insurance Broking Services will be the responsibility of the plan member.

Member Signature

Name:		Date:		Signature:	
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