STATE LIFE

INSURANCE CORPORATION OF PAKISTAN

PRE-AUTHORIZATION FORM-OPD

CORPORATE HEALTH INSURANCE PRE-AUTHORIZATION FORM FOR OPD

To be Filled by the Insured Member:

Insured Name:	Relation to Insured: ☐ Self ☐ Spouse ☐ Children ☐ Parent
Employer Name:	

Patient's Name:			Patient's Gender: ☐ Male ☐ Female
Patient/Employee Health Card I D :			Patient's Date of Birth: ☐☐ • ☐☐ • ☐☐☐☐
CNIC: ☐☐☐☐☐–☐☐☐☐☐☐☐–☐	Phone Residence:	Phone Office:	Mobile:

To be Filled by the Insured Member/Patient:

Name of Hospital/Clinic:	Required Appointment Date: ☐☐ ☐☐ ☐☐☐☐ +/- ☐☐ Days
Name of Doctor:	Nature of Visit: ☐ Sickness ☐ Accident
Clinical History:	

To be Filled by SLIC:

Eligibility Check: ☐ ELIGIBLE ☐ NOT ELIGIBLE	
Comments (Approved/Denied):	Week Number for 2024: ☐☐ Date: ☐☐ • ☐☐ • ☐☐☐☐
Assigned Limit:	Total Available Limit:
Date of Statement: ☐☐ • ☐☐ • ☐☐☐☐	Signature/Seal of Approving Authority

To be Filled by Concerned Hospital/Clinic:

Appointment Status: ☐ BOOKED ☐ DENIED	
Comments (If Any):	Appointment Date: ☐☐ • ☐☐ • ☐☐☐☐
Booked By:	Appointment Time: ☐☐ • ☐☐
Date of Statement: ☐☐ • ☐☐ • ☐☐☐☐	Signature/Seal of Hospital/Clinic/Doctor