NHIF 8d/10-11

Revised 2020

Pre-auth Request No._____ **L.O.U Number:** _____

DIAGNOSTIC IMAGING PRE- AUTHORIZATION FORM

PLEASE BE AS COMPREHENSIVE AND ACCURATE AS POSSIBLE WHEN COMPLETING THIS FORM. ERRORS OR OMMISSIONS MAY DELAY APPROVAL.

SECTION 1: PATIENT INFORMATION *(To be filled by the Patient/Guardian)*		
Surname: Other Names:		County:
NHIF Member No:	Patient's ID No/Birth Cert./ Notification No:	Patient's Phone No:
Relationship to Principal Member: Self: ☐ Spouse:☐ Child: ☐		Principal Member Phone No:
If patient is below 18 years, Name of Guardian:		Relationship to patient:
Do you have any other MEDICAL insurance cover? Yes ☐ No ☐		If YES, give details:
PATIENT OR AUTHORISED PERSON'S DECLARATION: I certify that the above information is correct and give specific consent for the imaging service to be done. I understand that it is an offence to knowingly make any false statement for purposes of obtaining any benefit under NHIF Act. **Signature:** _____ **Date:** _____		
SECTION 2: REQUEST FOR IMAGING SERVICE *(To be filled by the requesting doctor)*		
☐ Computerized Tomography Scan (CT-SCAN)		☐ Magnetic Resonance Imaging: (MRI)
Procedure Code: Description:		Procedure Code: Description:
Procedure Code: Description:		Procedure Code: Description:
Primary Diagnosis:		ICD 10 code:
Servicing Location: ☐ Inpatient ☐ Outpatient	Patient OPC/IPC NO.	Date of Service:
SECTION 3: REQUESTING CLINICIAN/SPECIALIST INFORMATION		
Facility Name: Facility Code:	**Requesting Doctor's Details** Name: ID No: Practice Specialty:	KMPDC No/License No:
CLINICAL INFORMATION: Justification for the radiology procedure request (brief treatment history, treatment plan, medication, and previous imaging results). *Facility stamp*		
PRACTITIONER DECLARATION: This is to certify that the intended imaging procedure is rightly indicated for the presenting condition of the beneficiary and the desired outcome shall be of value in managing the condition. **Requesting Doctor's Signature:** _____ **Tel. No**_____ **Date:** _____		
SECTION 4: IMAGING CENTRE *(To be completed by a radiologist at the imaging center where the image is done)*		
Facility Name:		Hospital Code:
Radiologist's Name:	Registration No.	ID No:
Is the member co-insured? Yes ☐ No ☐	If yes, give details:	
Outcome of procedure / Imaging Report comments: attach the MRI/CT-Scan report(s) *Facility stamp*		
PRACTITIONER DECLARATION: I certify that I have shared the radiological results with the client and instructed them to return the report to referring health care provider/practitioner. **Servicing Radiologist Signature:** _____ **Tel No**_____ **Date:** _____		

Notice: Any person/institution who/which knowingly files a statement of request or claim containing any misrepresentation or false, incomplete, or misleading information may be guilty of medical fraud punishable under law or as per the statutes of NHIF operation.

- All fields in this form are mandatory and **MUST** be completed to inform pre-authorization decision.
- Turnaround for prior-authorization response is **up to 72 hours once all relevant** information has been received.
- Need for MRI/CT scan shall be ascertained and prescribed by **Medical Specialist (Consultant).**
- Clinical justification and results of preliminary diagnostic examinations, where necessary, shall accompany the request.
- Procedure codes are as outlined in the claims processing manual and in the Hospital web application.
- The providers shall be responsible for ascertaining beneficiary's eligibility to utilize the procedure and treatment.
- Payment for services rendered is subject to verification of outcomes of care and beneficiary eligibility as at the date of service provision. Contractual obligations with the provider take precedence.
- Medical co-insurance declaration is **Mandatory**, failure to which approval will be withheld or monies recovered in case of falsification to obtain benefits.
- Authorization is based upon the medical information provided. If services, providers, or dates of services change from these indicated, NHIF must be notified prior to services being rendered
- **PATIENT OR AUTHORISED PERSON'S DECLARATION:** This declaration provides that the Principal member and beneficiary details are accurate and complete as per the form, that the medical information and treatment plan herein is accurate and can be utilized for medical insurance purposes.
- **HOSPITAL DECLARATION:** This declaration provides that the hospital is declared and contracted, and is operational under the provisions on location, hospital code and contracted services. It also provides that the member/beneficiary is eligible for access to the contracted benefits as per the clauses on "OBLIGATIONS OF THE HEALTH FACILITY", and the terms of engagement. It also provides that the hospital has taken due diligence to identify the beneficiary and provided necessary details on the eligible benefits and financial liability.
- **PRACTITIONER DECLARATION:** The listed beneficiary has presented for clinical management and the practitioner is duly qualified and registered by the relevant authority in Kenya.