PSMAS
PREMIER SERVICE
MEDICAL AID SOCIETY

Pre-authorization Request Form

Section 1 (To be completed by member/patient)
Name of Medical Aid Society:
Principal Member's Name:
Member's Contact Number:
Membership number: ☐☐☐☐☐☐☐☐☐☐☐☐ Suffix: ☐☐
Patient's Name:
Date of Birth:
Sex:
Patient's Contact Number:

Section 2
Examinations Requested:
Relevant Clinical History: (Symptoms, examination findings and previous treatment)
Provisional Diagnosis:
Previous Investigations:

Section 3

Doctor's Name (Print): ....

Doctor's Signature: ....

Date: ..../.................../....................

Hospital Stamp