MSH INTERNATIONAL
SIACI SAINT HONORE GROUP

www.msh-intl.com/americas

NORTH & SOUTH AMERICA
2900, 605 – 5th Avenue SW
Calgary, Alberta T2P 3H5
CANADA
Tel: +1 403 537 8823
Fax: +1 403 451 1591
precert@msh-intl.com

EUROPE
82, rue Villeneuve
92 587 Clichy Cedex
FRANCE
Tel: +33 (0) 1 44 20 82 20
Fax: +33 (0) 1 44 20 99 03
precert@msh-intl.com

MIDDLE EAST & AFRICA
DIFC, Liberty House, Office 304
P.O. Box 506537 Dubai
UNITED ARAB EMIRATES
Tel: +971 4 365 1308
Fax: +971 4 363 7327
precert@msh-intl.com

ASIA
East Unit, 5F, North Tower, Building 9
Lujiazui Software Park, No. 20
Lane 91, E Shan Road, Pudong
Shanghai P. R. CHINA 200127
Tel: +86 21 6187 0595
Fax: +86 21 6160 0153
precert@msh-intl.com

Precertification and direct payment request

IMPORTANT NOTE: Please fill out the whole document and send it back to MSH INTERNATIONAL at least 10 days before the service date. **MANDATORY FIELDS ARE MARKED WITH THE " * " SYMBOL. PLEASE MAKE SURE TO COMPLETE THEM. AN INCOMPLETE APPLICATION WILL DELAY THE PROCESSING OF YOUR PRECERTIFICATION REQUEST OR MAY PREVENT US FROM ISSUING A LETTER OF GUARANTEE.** Please note that Pre-certification is not for dental services, vision care or for treatment in series (e.g.: Physical Therapy).

1 General Information

- **Main insured:**

*Last Name _____ *First Name _____ *ID Number _____

Phone _____ Fax _____ E-mail _____

- ***Patient:** (If different from main insured) ☐Female ☐Male

*Last Name _____ *First Name _____ *Date of Birth _____
(Maiden name if applicable) (DD/MM/YYYY)

Phone _____ Fax _____ E-mail _____

- ***Expected date of service:** _____ (DD/MM/YYYY)

***Please also include supporting medical notes (medical report detailing the diagnosis and treatment to follow / or / pregnancy certificate for maternity indicating the estimated due date).**

2 Type of procedure

- ***Diagnosis:** _____ ***Treatment:** _____

☐Hospitalization
☐Out-Patient Surgery
☐Out-Patient Treatment or exam (Diagnostic Testing / Lab)

Maternity:
☐Vaginal Delivery
☐C-Section

- ***Services in the USA:**
  *ICD9 Code(s): _____
  *CPT / HCPCS Code(s): _____

*Services in Brazil CBHPM/ABM codes: _____

*Release of Medical Information:

I, _____, hereby give consent for all medical staff involved in my past or present
(patient's name & first name)
treatment to release any relevant information to the medical department of MSH INTERNATIONAL.

3 Hospital & Physician's information

- ***Facility (Billing) Name:** _____ Contact Name / Department: _____

*Address _____

*City _____ *Zip/Postal Code _____ *Country _____

*Phone _____ *Fax _____ E-mail _____
(including country area code)

- ***Physician's Name:** _____

*Address _____

*City _____ *Zip/Postal Code _____ *Country _____

*Phone _____ *Fax _____ E-mail _____
(including country area code)

4 Cost estimate & Direct payment

- ***Do you wish us to try to arrange payment directly to:**
  a) Hospital: ☐Yes ☐No *Estimated Cost: _____
  b) Medical Team: ☐Yes ☐No *Estimated Cost: _____
  (all professionals involved in the procedure (surgeon, assistant/helper, anaesthesiologist, etc.)

- ***Are you planning to pay directly:** ☐Yes ☐No

Privacy: Protecting Your Personal Information

At MSH INTERNATIONAL, we recognize and respect the importance of privacy. When you submit a precertification, the insurers establish a confidential file that is kept in the offices of the insurers or the offices of an organization authorized by the insurers. We limit access to information in your file to insurer staff and/or the insurers who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use this information for the purpose of assessing your precertification and administering the group benefits plan. Personal information is protected from unauthorized use and disclosure in accordance with the *Freedom of Information and Protection of Privacy Act*.