



ace life

ACE Life

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ACE Life Authorization Form

Provider's Details

Provider's Name Tel No.

Doctor's Name Fax No.

Patient's Details

Patient's Name Contact No.

Plan No. Cert Subscriber No.

Illness Details

Chief Complaints & Duration

Please indicate the date symptoms/signs first appeared

Please indicate the date of any previous treatment/consultation

Provisional Diagnosis

Diagnosis

Service Details

Please tick your request

Hospital Admission Outpatient Surgery MRI CT Scan TMT

Echocardiography Holter Monitor No. of Physiotherapy Sessions

Others, please indicate

Estimated Cost

Name of Surgery

No. of Necessary Admission Days

Important Notes

1. This authorization is valid for one week from the approval date.
2. The insurance company reserves the right to revoke its initial decision if it comes across new information that will alter the initial decision.

FOR THE USE OF ACE LIFE

ACE Decision

Signature

Approved No. of days Date