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| **MEMBER DETAILS** | **BENEFIT DETAILS** |
| **MEMBER NAME :****INSURANCE PLAN :****DHA MEMBER ID :****EID : DOB :****CARD NUMBER : GENDER :****MOBILE NUMBER : START DATE :****MEMBER NETWORK : END DATE :** | **DEDUCTIBLE :****OP CO-PAYMENT :****DENTAL : DETAL CO-PAY :****VACCINATION : VACCINATION CO-PAY :****MATERNITY : MATERNITY CO-PAY :****ALTERNATIVE MEDICINE: ALTERNATIVE MEDICINE CO-PAY :** |
| **PRE-APPROVAL PROTOCOL:** |
| **SUBJECTIVE** |
| **OBJECTIVE** |
| **TEMP: PR: RR: BP: WEIGHT:** |
| **P****L****A****N** | **PHARMACEUTICALS** |
| **P****L****A****N** | **DIAGNOSTIC PROCEDURES** |
| **Facility Name :****Telephone No. :****Physician’s Name :****Physician’s Stamp & Signature :** | **Patient Registered by :****Date & Time :****Card Holder’s Signature :****“I hereby authorize any MedNet personnel to access my medical file”** |