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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”** | |