Request for
Pre-Certification Form

To be completed by the Insured

MWG INTERNATIONAL
A division of Morgan White Group

3191 Coral Way, 7th Floor
Miami, FL 33145

Part I: Primary Insured Information

Last Name	First Name	I.
Customer Number	Email Address	Phone (Home/Cell)
Address		DOB Day/Month/Year

Part II: Claimant Information

Last Name	First Name	I.
DOB Day/Month/Year	Sex ☐ Female ☐ Male	Relationship to Primary Insured ☐ Self ☐ Spouse ☐ Child

Part III: Accident Related Services

Date of injury or accident (Day/Month/Year)	Did the injury occur while working? ☐ Yes ☐ No	Is injury due to automobile accident ☐ Yes ☐ No
How did injury or accident occur?		

Part IV: Illness Related Services

Current Diagnosis	Specialty of attending Physician
Date first symptoms occurred *(Day/Month/Year)*	Address of attending Physician
Name of treating Physician	Telephone(s)
Specialty of treating Physician	Name of any other Physician you have seen
Address of treating Physician	Specialty of any other Physician you have seen
Telephone(s)	Address of any other Physician you have seen
Name of Physician who is attending for the current condition *(if is different from the treating Physician)*	Telephone(s)

I declare the answers to the questions are true and complete to the best of my knowledge and belief. I authorize any physician, medical institution, insurance company, employer, labor union or association to release information to MWG International as is required to properly process this exam. A photostatic copy of this authorization shall be considered valid as the original.

_____ Date _____ /_____ /_____

Insured Signature (patient)
(If the Insured (patient) is under age, the Primary Insured shall sign this form)

Request for Pre-Certification Form *(continued)*

To be completed by the treating Physician

Part V: Patient Information

Name of Patient	DOB Day/Month/Year	Sex ☐ Female ☐ Male

Date on which patient first consulted you *(Day/Month/Year)*	Date on which first symptom or accident occurred *(Day/Month/Year)*	Date on which patient first consulted you for symptom *(Day/Month/Year)*

Part VI: Medical History

History of present illness	
Past Medical/Family/Social History	
Physical Examination	Date first symptoms occurred *(Please attach results)*
Diagnosis *(ICD-9)*	Plan or treatment *(CPT-Code)*
Hospital to perform the treatment	Date to perform the treatment *(Day/Month/Year)*
Address of treating Physician	Specialty of any other Physician you have seen *(Please list any other Physician consulted for same condition)*

FEES: Surgeon *(if applicable)* _____ 1st Assistant *(if applicable)* _____ Anesthesiologist *(if applicable)* _____

_____ Date _____ /_____ /_____

Signature of Physician

_____

Medical License Number

Request for Pre-Certification Form *(continued)*

To be completed by the treating Physician

Part VII: Maternity Precertification

Uterus enlarge measurement	Date of last menstrual period *(Day/Month/Year)*
Time period of pregnancy	Expected date of delivery *(Day/Month/Year)*
Maternity Progress	
FEES: Normal Delivery Surgeon _____ Anesthesiologist _____ 1st Assistant _____ Pediatrician _____	
FEES: Cesarean Surgeon _____ Anesthesiologist _____ 1st Assistant _____ Pediatrician _____	
Hospital for Delivery or Cesarean	
Physician Name	Phone
Address	

_____ Date _____ /_____ /_____

Signature of Physician

_____

Medical License Number

NOTE: *If additional information is needed, it will be requested by the Administrator.*

GUARANTEE OF PAYMENT AND PRECERTIFICATION PROCESS

Precertification must be completed prior to a hospital admission or confinement.

1. In the event of a non-emergency hospital confinement, the Insured or the admitting Physician must contact the Administrator a minimum of fifteen (15) days prior to admission to certify the admission based upon proven medical necessity. The Administrator must receive complete medical records from the treating Physician.

2. In the event of an emergency admission, the hospital in which the Insured is confined must contact the Administrator within forty-eight (48) hours of admission and/or confinement, regardless of whether or not said individual has been discharged.

3. In either event of Hospitalization, the Administrator must receive complete medical information to evaluate the case, including the admission report from the hospital, diagnosis, treatment required and expected date of discharge. If surgery was required, the Administrator will need the surgeon's report and the anesthesiologist report.

4. When notified in advance, and if the claim is considered admissible, the Administrator will send a guarantee of payment to the hospital in accordance with the Certificate conditions the Primary Insured has chosen. The Administrator will settle the claim directly with the Hospital. Failure to comply will result in reduced benefits.