KENINDIA
ASSURANCE CO. LTD
*The Preferred Insurer in Kenya*

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# PRE-ADMISSION NOTIFICATION FORM

***Please ensure you complete the entire form***

***AND SEND BY FAX, EMAIL, OR HAND DELIVER TO KENINDIA MEDICAL INSURANCE DIVISION***

Name of Patient.....DOB.....

Membership No.....Employee/principal member.....

Employer..... Date of admission.....

The above named patient is (scheduled for procedure/admitted) at.....hospital.

Diagnosis.....

Presenting complaint.....

.....

Is the condition chronic or recurring?.....

Management.....

.....

Any procedure(s) to be done?.....

Estimated Cost.....

Estimated hospital stay.....

Under care of Dr.....

Office Telephone No.....

Cell Phone .....

| | |
|---|---|
| Panel Doctor | |
| Private Doctor | |

Dr.'s Signature.....Date.& stamp.....