GLOBAL BENEFITS GROUP
Insurance Without Borders

Pre-Authorization Request

SUBMIT THIS FORM TO GBG ASSIST:

Email:gbgassist@gbg.com; Fax: +1-905-669-2524; Phone: Toll Free USA/Canada: +1-866-914-5333; Worldwide Collect: +1-905-669-4920

COMPLETION OF ALL FIELDS BELOW IS REQUIRED TO PROCESS THIS AUTHORIZATION REQUEST.

If not a medical emergency as defined by your policy contract, you must wait until you have a written authorization from GBG Assist before proceeding with any procedure requiring pre-authorization. Please see your policy for a list of those procedures, or visit www.gbg.com. Otherwise, penalty co-pay will be applied to your claims, and the provider may decline to direct bill us. Your policy has requirements regarding the pre-authorization of certain treatments/procedures. Please refer to your policy for further details. In order to obtain pre-authorization of services, please complete the below form and ensure to provide all relevant details. Please note that this form can be completed online at www.gbg.com. Once you have completed, please submit the form along with all pertinent medical records to substantiate the medical necessity for your upcoming treatment to gbgassist@gbg.com. As part of the pre-authorization process you may be requested to obtain and submit additional items needed to authorize your procedure. Once all of the relevant items have been received you will be notified of the results of the review. Please note that non-emergency authorizations may take up to 5 business days to complete.

A. MEMBER INFORMATION – please write legibly		
Name (Last, First, MI):	**Alias:**	**Date of Birth:**
Member ID Number:	**Email:**	**Phone Number:**
Diagnosis, Symptom, or Complaint (medical necessity for requested procedure):		
Is the member/dependent having surgery: ☐ **Yes** ☐ **No**		
Is the member/dependent being admitted to the hospital overnight: ☐ **Yes** ☐ **No** **If yes, expected number of days/duration:**		
Procedure or treatment name:		
Expected date of surgery or inpatient admission (MM/DD/YY):		
Anticipated type of delivery (for maternity admissions only): ☐ **Vaginal** ☐ **Cesarean Section**		
Estimated cost Physician/Surgeon: **Currency:**	**Estimated cost Hospital/Facility:** **Currency:**	
Hospital name: **Country of location:**	**Tax ID Number (USA Hospitals Only):**	
First date injury, illness, or accident occurred (MM/DD/YY): **Describe how accident occurred if applicable:** **First date you ever received treatment for this condition (MM/DD/YY):**		
Describe previous treatment(s) received for this condition, if any, including dates (ex. medicines, consult, surgery, hospitalizations):		
Do you have any other insurance/coverage? ☐ **Yes** ☐ **No** **If yes, please confirm name of Insurer, ID#, and Group Number:**		

B. PHYSICIAN INFORMATION	
Treating Physician/ Surgeon Name:	**Tax ID Number (USA Doctors Only):**
Address:	**Email:**
Telephone Number:	

PLEASE ATTACH EXAM AND/OR DIAGNOSTIC REPORTS TO SUPPORT THE MEDICAL NECESSITY OF THIS REQUEST

C. SIGNATURE

Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

_____ _____

Signature **Date**

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