Appendix 1

DEPARTMENT OF HEALTH

MALTA

National Contact Point
Cross Border Care,
Tel: 22992381 email: crossborderhealth@gov.mt

REQUEST FOR **PRIOR AUTHORISATION** OF A HEALTH CARE SERVICE UNDER THE CROSS-BORDER Regulations

Section 1: Patient Details			
Surname:		Gender:	☐ Male ☐ Female
Name:		Date of birth:	
I.D. No.:		Tel. No.:	
Email:		Mobile No.:	
Address:	Permanent residential address in Malta	Alternative address for correspondence	
Is the patient entitled to healthcare from the Public Health Care System in Malta? ☐ Yes ☐ No		National Insurance No.: _____	

*Member State where patient is entitled to Health Care **Competent Institution: responsible for the publicly funded national health care system

Section 2: Health Care Service/s	
What is the **diagnosed** medical condition for which the patient is planning to receive treatment abroad?	

Details of the health care service(s) / treatment(s) for which prior authorisation is being sought:		
Treatment Abroad	**Please specify**	**Envisaged dates of health care**
Investigations (e.g. blood tests / scans)		
Consultation		

Appendix 1

Medication/drugs		
Estimated stay in health care setting		
What is the estimated total cost of treatment?		
What is the reason you are seeking to obtain treatment abroad?		
Will you require follow-up treatment from the Public Health Care Service in Malta on your return?	☐ Yes ☐ No	

Section 3: Health Care Facility where patient plans to receive treatment abroad	
Name of health care facility:	
Name of treating clinician:	
Address of health care facility:	
Country:	
Telephone number:	
Email address:	
The health care provider is in the:	☐ Public Sector ☐ Private Sector

Section 4: Required Documentation
☐ Ticket of referral: a letter/report from the patient's Specialist (as per Specialist Accreditation Register) must be attached, with information on the patient's condition/diagnosis, and other relevant conditions the patient may have. This must also include confirmation of the medical need for treatment(s).

Appendix 1

Section 5:Declaration and Signature		
☐ I declare that to the best of my knowledge all the information given in this form is correct and complete.		
☐ I understand that the Department of Health is not liable for health care received abroad.		
☐ I understand that if approved by the Department of Health, reimbursement of eligible treatment costs are up to the Maltese Public Health Care System National tariffs active at the time of application, or the actual cost of the healthcare service received abroad, whichever is the lowest, and does not include travel, accommodation or other expenses.		
……..... Patient's signature	_____ Date	……..... Signature of Parent / Legal Guardian / Custodian of minor or if incapable of taking care of his/her own affairs
……..... Full Name and Surname (block letters)	_____ I.D. number of signatory	……..…… Full Name and Surname (block letters) …… Relation to patient

OFFICE USE: Case No: _____

Officer receiving form: _____ _____

Date: _____

Updated: 20/9/16