AMARIZ

REQUEST FOR PRIOR AUTHORISATION FOR PHYSIOTHERAPY AND ORTHOPTICS (FOR MORE THAN 10 SESSIONS)

PERSON RECEIVING TREATMENT AND THE PERSON INSURED:	
Name and Surname	
Date of Birth	
Client Reference	

ACTS TO BE CARRIED OUT:		
Code of the act and its coefficient		
Number of sessions		
Date of the medical prescription		
Acts needing to be carried out at home	YES ❒	NO ❒
Emergency acts	YES ❒	NO ❒

REASON FOR TREATMENT:	
Illness ❒ Nature of the illness Date of first medical diagnosis Act relating to a long-term illness	…… …… …… / …… / …….. YES ❒ NO ❒
Maternity ❒ Presumed date of conception or date of childbirth	…… / …… / ……..
Occupational injuries or illness ❒ Date	…… / …… / ……..

Signature and stamp of practitioner

Please attach a medical prescription