



# 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 <input type="checkbox"/> NO <input type="checkbox"/>
Emergency acts	YES <input type="checkbox"/> NO <input type="checkbox"/>

REASON FOR TREATMENT:	
<b>Illness</b> <input type="checkbox"/> Nature of the illness  Date of first medical diagnosis Act relating to a long-term illness	 ..... ..... ..... / ..... / ..... YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>Maternity</b> <input type="checkbox"/> Presumed date of conception or date of childbirth	 ..... / ..... / .....
<b>Occupational injuries or illness</b> <input type="checkbox"/> Date	 ..... / ..... / .....

<b>Signature and stamp of practitioner</b>
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**Please attach a medical  
prescription**