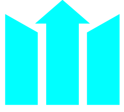

TRIDENT

INSURANCE COMPANY LIMITED

"The Right Choice"

PRE-ADMISSION NOTIFICATION FORM

1ST FLOOR, CAPITOL HILL TOWERS, CATHEDRAL ROAD • P. O. BOX 55651, CITY SQUARE, NAIROBI-00200
TELEPHONE: (+254-20) 2721710 • FAX: (+254-20) 2726234
E-MAIL: medical@trident.co.ke • Website: www.trident.co.ke

Please ensure you complete the entire form AND SEND BY FAX, EMAIL, OR HAND DELIVER TO **TRIDENT INSURANCE MEDICAL DIVISION**

Name of Patient... DOB...

Membership No... Name of Principal..

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...

Contacts: Office Telephone No...

Cell Phone..

Panel Doctor	
Private Doctor	

Dr.'s Signature.. Date & Stamp...

FOR ANY UNPAID BILL NOT NOTIFIED AFTER 60 DAYS IS DEEMED AS FORFEITED