Application for prior approval – business trip

For Danish speaking please use the Danish application form of respect to your Medical Doctor. You can apply for a prior approval if you suffer from a condition/ symptom, that means you do not comply with insurance requirements.

Send the completed application to **medicinsk@gouda.dk**

For Gouda's use:	
Godkendt:	☐
Forbehold:	☐
Afslag:	☐

1. Applicant information

Name:	CPR/date of birth:
Adress:	
ZIP code:	City:
Phone:	E-mail:
Company:	Policy no.:

2. Travel details

Destination (country):	
Departure date:	Return date:
Travel purpose:	

3. Medical information (to be completed by the Medical Doctor)

To the Medical Doctor:
Your patient suffers/has suffered from a condition/symptom which means that he/she does not comply with the insurance requirements.

For Gouda to consider insurance coverage and possible reservations please fill out **3. Medical information** and **4. Clinic information** on the next page.

If the application is not adequately filled it will be denied.

You are encouraged to attach medical reports.

Expences related to completing the form is to be held by the applicant.

For which condition/symptoms does your patient need prior approval?
When did the symptoms first show?
Which need for treatment is likely to occur?

3. Medical information (continued)

Are symptoms still present? ☐ Yes ☐ No	If yes, what are they?	If no, when did the symptoms stop?
Has surgery been necessary? ☐ Yes ☐ No	If yes, what kind?	Time and place for surgery:
What treatments are given/has been given over the past 6 months? (Describe name and dosis of medicine)		When?
Have there been any changes in treatment within the past 6 months? ☐ Yes ☐ No		
If yes, which changes?		When?

Has the patient been hospitalised within the past 6 months? ☐ Yes ☐ No	If yes, where and when?
Does the patient suffer from other conditions/ symptoms? ☐ Yes ☐ No	If yes, which and what treatment has been given?

Is the patient awaiting any treatment or further examination? ☐ Yes ☐ No		
If yes, which?	When?	
Has the patient been on sick lea ve? ☐ Yes ☐ No	From (date):	To (date):

4. Clinic information

Clinic name and address:	
Date:	Signature of Medical Doctor:

5. Date and signature of applicant

Date:	Signature of applicant: