The Avenue Group - Credit Client Instruction Form

_____ (Client's Name)

This form is designed to give clear instructions on how the Client would like Avenue to handle the following issues.

The form should be accompanied by a copy of your company's medical policy document which clearly outlines the benefits, limits and exclusions of your medical scheme.

In case of an Emergency Contact:

1. _____ Tel: _____ (Office)
   (Name & Position)
   Tel: _____ (Mobile)

2. _____ Tel: _____ (Office)
   (Name & Position)
   Tel: _____ (Mobile)

Please confirm the following:

1. *Verification of members and / or dependants* When seeking medical services, members will present :-
   - ☐ A letter from the company
   - ☐ An Avenue Healthcare Sick Sheet (duly signed & authorized)
   - ☐ The member's Employment card; National ID Card or other photo ID.
   - ☐ Other _____

2. *Does your company have it's own panel of specialists?* ☐ YES ☐ NO

   If yes, kindly attach the full list of specialists

   If no, *Would you like our doctors to refer members to **our** panel of specialists* (please refer to the attached Avenue Healthcare Specialist panel)
   - ☐ YES
   - ☐ YES (Some as indicated)
   - ☐ NO

3. *Are there any exclusions under your company medical plan?*

   ☐ YES ☐ NO - The Company will pay for the treatment of all exclusions.

   (If YES, Please refer to the attached AHC Exclusion List or attach a copy of your Company's Medical Exclusions list)

   - ☐ Patient to pay all
   - ☐ Company to pay all
   - ☐ Company to pay some, according to attached list.
   - ☐ Other _____

Inpatient Services

4. *Patients should be admitted to :-* (to be completed by clients applying for ***outpatient only*** credit facility terms)
   - ☐ Avenue Hospital
   - ☐ Kenyatta National Hospital
   - ☐ Other Hospital(s) *(please specify)* _____
   - ☐ N/A - Members are covered under Avenue Hospital Inpatient Only Medical Plan

5. *Payment for admission to hospital* (to be completed by clients applying for ***outpatient only*** credit facility terms)

   ☐ Patient to pay

   ☐ Company to pay

   ☐ Insurance to pay: Insurance Co: _____

   ☐ Company to pay on written authorization only

   ☐ Other _____

6. *Will the company pay for ICU care?* (to be completed by ***all clients*** applying for credit facility terms)

   ☐ Yes

   ☐ Yes *only* to a limit of Kshs. _____

   ☐ No Family Members to pay

   ☐ No ICU is covered under our Inpatient policy with _____

B: Exclusions (Please see the AHC Exclusions list attached)

1. *Payment for excluded illnesses or treatments (both outpatient & inpatient services)*

   ☐ Patient / Family Members to pay

   ☐ Company to pay

   ☐ Company to pay some, according to attached list.

   ☐ Company to pay on written authorization only

Signed: _____ **Designation:** _____

Name : _____ **Date:** _____

Insert Company Stamp:

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_____ (Client's Name)

Appendix A

Standard Exclusions under the Avenue Medical Plans
Credit Client Payment Options

Co. to Pay	Patient to pay	
☐	☐	Chronic conditions – diseases that require long term care and are incurable.
☐	☐	Pre-existing conditions – conditions which originated before commencement of cover.
☐	☐	AIDS and AIDS related disorders
☐	☐	Chronic mental illness, drug and alcohol dependence and substance abuse related illness.
☐	☐	Illness or injury arising from illegal acts committed by the patient.
☐	☐	Cost of scientifically unrecognized drugs and treatments, herbal medicines, food supplements, vitamins (other than for treatment of deficiency), accupressure, acupuncture, chiropractors, hydrotherapy, health spas, homeopathy, home nursing care, treatment by a medical practitioner not registered by the Kenya Medical Practitioners Board, illnesses arising from any of the above.
☐	☐	Antenatal care
☐	☐	Dental examinations and treatment, except in case of severe accidental damage.
☐	☐	Eye examinations and corrective lenses.
☐	☐	Cosmetic treatment
☐	☐	Medical tests and treatments on request, vaccinations, contraceptives, infertility treatment, desensitization and allergen tests, and any elective treatment or test which is not for acute illness.
☐	☐	Ambulance or evacuation.
☐	☐	MRI
		Inpatient Cover
☐	☐	All of the above, plus
☐	☐	Maternity Care.
☐	☐	Non- emergency gynaecological or elective surgery.
☐	☐	ICU

Signed: _____ **Designation:** _____

Name : _____ **Date:** _____

Insert Company Stamp:

In the absence of the above specifications, AHC shall assume that no limits or exclusions apply.