



FijiCare Insurance Limited

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Diagnostic Activation Form

IMPORTANT: Ensure all details are completed.

Programme Name: _____

Medical # / F.N.P.F #	Date of Birth	Patient First Name	Patient Surname

TYPE OF TEST REQUESTED

Pathology (Specify)

Total Cost: \$ _____

Radiology (Specify)

Total Cost: \$ _____

MEDICAL DETAILS

Reason for Test (Please write clearly)			
Date of onset of symptoms		Date of Consultations	

REFERRING DOCTRS DETAILS

Doctors Name		Signature		Date	
Phone		Mobile Phone		Fax No	

Official Use Only

FIL & Healthplus Decision: Approved / Not Approved **Amount Approved:** \$ _____
(Circle one)

Comments:

Decision By: _____ **Signature:** _____ **Date:** _____