CarePay Ltd.
114, Manyani East Road
Off James Gichuru Road
P.O Box 52887-00100

T : +254 726 473 002
E : info@carepay.com
W : www.carepay.com

M-TIBA IN-PATIENT PRE-AUTHORIZATION FORM

Name of Hospital .....
Email .....
Telephone No. .....

Patient Details

Patient Name: .....
Date of Admission .....
Membership No: .....
Date of Birth ..... ID/Passport No. .....
Phone No .....
Insurance Company Name: ....
Employer/Scheme Name: .....

Next of Kin

Name: .....
Phone Number: .....
Relationship to Patient: .....

Medical Information (To be filled by the Doctor)

Current presenting complaints and duration .....
.....
Any Prior treatment .....
.....

All relevant Medical/Surgical history .....
.....
.....
Laboratory investigations and findings .....
.....
.....
Radiology investigations and findings .....
.....
.....
Detailed diagnosis .....
.....
.....
Management plan .....
.....
.....
.....

Treatment/procedure
1.
2.
3
4.
5.

Estimated length of stay (days). .....
Estimated cost of treatment (Ksh) .....
Doctor's Name: .....
Signature and Stamp .....
Doctor's Phone Number .....

NOTE: ***Please email this completed and signed form to care@mtiba.co.ke***
In addition, please raise the associated claim on the M-TIBA portal and attach scanned copies of.
(1) this form, (2) discharge summary (IP), (3) itemized bill , (4) Any other relevant documentation.
For any questions or clarifications please call: 0800721253 or 0709071000.

NOTE: *2023 Version – Subject to updates notified by CarePay to Service Provider in writing.*
Updates will take effect 48 hours after the notification was sent.