DAP EN 02 2024

REQUEST FOR PRIOR AUTHORISATION OR EXTENSION OF PRIOR AUTHORISATION

to be sent to the appropriate Settlements Office of the Joint Sickness Insurance Scheme (JSIS): see address on last page

Surname and first name of member:.....
Pers./Pension No:.....
Institution and place of employment:..... **Office address:**.....
Tel : .....
Private address if you are retired / E-mail:
.....
.....

Date of termination of employment/ date of end of contract:..... **(For Temporary Agents /Contract Agents)**

☐ Request for **PRIOR AUTHORISATION** for [1] :

☐ Member of the Scheme ☐ spouse or recognised partner ☐ child ☐ person treated as a dependant child.

Surname, first name:..... Date of birth:.....

☐ Request for an **EXTENSION** of the prior authorisation for [1] **:**

☐ Member of the Scheme ☐ spouse or recognised partner ☐ child ☐ person treated as dependant child.

Surname, first name :..... Date of birth:.....

Reference of prior decision relating to PA: ..... End validity date:.....

☐ For treatments **exceeding** the maximum number of sessions foreseen per year without prior authorisation. (specify type of treatment) [(4)]

.....

☐ **On prescription / detailed medical report (to be attached in a sealed envelope for the attention of the Medical Adviser)** [2]

from Dr ..... on: .....

Is this request in relation to :

☐ **SERIOUS ILLNESS: decision reference** .....**End validity date** .....