PRE AUTH REQUEST FORM

CASHLESS PRE AUTHORISATION FORM

Details of the hospital:

a) Name of the Hospital:

b) Address:

c) ROHINI ID: d) Email ID:

To be filled by insured/patient:

a) Name of the Patient: _____

b) Gender: ☐ Male ☐ Female ☐ Third Gender c) Age: _____ d) Date of Birth: D D M M Y Y Y Y

e) Contact number: _____ f) Contact number of attending relative: _____

g) lnsured' s Card ID number: _____

h) Policy number/Name of Corporate: _____

i) Employee ID: _____

j) Currently do you have any other Mediclaim/health insurance: ☐ Yes ☐ No

If yes:

i. Company Name: _____

ii. Give Details: _____

k) Do you have a family physician: ☐ Yes ☐ No

l) Name of the family physician: _____

m) Contact number, if any: _____

n) Current address of insured patient: _____

_____

o) Occupation of insured patient: _____

(please complete declaration of this form)

To be filled by treating doctor/hospital

a) Name of the treating doctor: _____

b) Contact number: _____

c) Nature of illness/disease with presenting complaint: _____

d) Relevant critical findings: _____

e) Duration of the present ailment: _____ Day(s)

i) Date of first consultation D D M M Y Y Y Y

ii) Past history of present ailment, if any _____

f) Provisional diagnosis: _____

i) ICD-l0 code: _____

g) Proposed line of treatment:

i) Medical Management ( )

ii) Surgical Management ( )

iii) Intensive Care ( )

iv) Investigation ( )

v) Non-allopathic treatment ( )

h) If investigation/Medical Management, provide details: _____

i) Route of drug administration: _____

j) lf surgical, name of surgery: _____

i) ICD-l0 PCS code: _____

k) If other treatment, provide details: _____

l) How did the injury occur? _____

m) ln case of accident

i) Is it RTA: ☐ Yes ☐ No

ii) Date of lnjury: D D M M Y Y Y Y

iii) Report to Police: ☐ Yes ☐ No

iv) FIR No.: _____

v) Injury/Disease caused due to substance abuse/alcohol consumption ☐ Yes ☐ No

vi) Test conducted to establish this (if yes, attach report) ☐ Yes ☐ No

n) In case of maternity ☐ G ☐ P ☐ L ☐ A

i) Expected date of delivery: D D M M Y Y Y Y

Details of patient admitted

a) Date of admission: D D M M Y Y Y Y

b) Time of admission: H H M M

c) Is this an emergency/planned hospitalization event ☐ Emergency ☐ Planned

d) Mandatory past history of any chronic illness If yes, since month/year: _____

i) Diabetes: _____

ii) Heart disease: _____

iii) Hypertension: _____

iv) Hyperlipidemias: _____

v) Osteoarthritis: _____

vi) Asthma/COPD/Bronchitis: _____

vii) Cancer: _____

viii) Alcohol/Drug abuse: _____

ix) Any HIV/ STD Related ailment: _____

x) Any other ailment, give details: _____

e) Expected number of days/stay in hospital_____Day(s)

f) Days in ICU_____Day(s)

g) Room Type: _____

h) Per day room rent+nursing and service charges+ patient's diet: _____

i) Expected cost of diagnosis + investigation: _____

j) ICU charges: _____

k) OT charges: _____

l) Surgeon's Professional Fees + Anesthetist Fees + Consultation Charges: _____

m) Medicines + Consumables + Cost of Implants (if applicable, please specify) _____

n) Other hospital expenses, if any: _____

o) All-inclusive package charges if any applicable: _____

p) Sum total expected cost of hospitalization: _____

DECLARATION (Please read very carefully)

We confirm having read, understood, and agreed to the Declarations within this form

Name of the treating doctor _____

Qualification_____

Registration number with State code _____

Hospital Seal (Must include Hospital ID)	Patient/lnsured Name and Sign

Declaration by the patient /representative

a) I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/TPA aftermy discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.

b) Payment to hospital is governed by the terms and conditions of the policy. In case the lnsurer/TPA is not liable to settle thehospital bill, I undertake to settle the bill as per the terms and conditions of the policy.

c) All non-medical expenses, and expenses not relevant to the current hospitalization; and the amounts over & above the limit authorized by the Insurer/TPA not governed by the terms and conditions of the policy will be paid by me.

d) I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found tobe false or incorrect, I forfeit my claim and agree to indemnify the Insurer/TPA.

e) I agree and understand that TPA is in no way warranting the service of the hospital & that the Insurer/TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.

f) I hereby warrant the truth of the foregoing particulars in every respect, and I agree that if I have made or shall make any false or untrue statements, suppression, or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.

g) I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer/TPA.

h) "I/We authorize the Insurance Company/TPA to contact me/us through mobile/email for any update on this claim?".

a) Patient's/Insured's Name: _____

b) Contact number: _____ c) Email ID (optional): _____

d) Patient's/Insured's Signature: _____

Date: D D M M Y Y Y Y Time: H H M M

Hospital declaration

a) We have no objection to any authorized TPA/Insurance Company official verifying documents pertaining to hospitalization.

b) All valid original documents duly countersigned by the insured/patient as per the checklist below will be sent to TPA/Insurance Company within 7 days of the patient's discharge.

c) We agree that TPA/Insurance Company will not be liable to make the payment in the event of any discrepancy between the facts in this form and the discharge summary or other documents.

d) The patient's declaration has been signed by the patient or by his representative in our presence.

e) We agree to provide clarifications for the queries raised regarding this hospitalization and we take sole responsibility for any delay in offering clarifications.

f) We will abide by the terms and conditions agreed upon or agreed to MOU.

g) We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates, except costs towards non-admissible amounts (including additional charges due to opting for higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in the package).

h) We confirm that no recoveries would be made from the deposit amount collected from the insured, except for coststoward non-admissible amounts (including additional charges due to opting for higher room rent than eligibility/ choosing separate line of treatment which is not envisaged/considered in the package).

i) In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA/Insurance Company reserves the right to recover the same from us (the Network Provider) and/or take necessary action, as provided under the MOU or applicable laws.

Hospital Seal **Doctor's Signature**

Date: D D M M Y Y Y Y

Time: H H M M

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How PreAuths Pro Works

01 Select assigned insurer / TPA template

02 Enter patient and hospital details once

03 Preview the generated PDF

04 Download and review before submission

Why hospitals choose PreAuths Pro

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- Structured hospital form workflow
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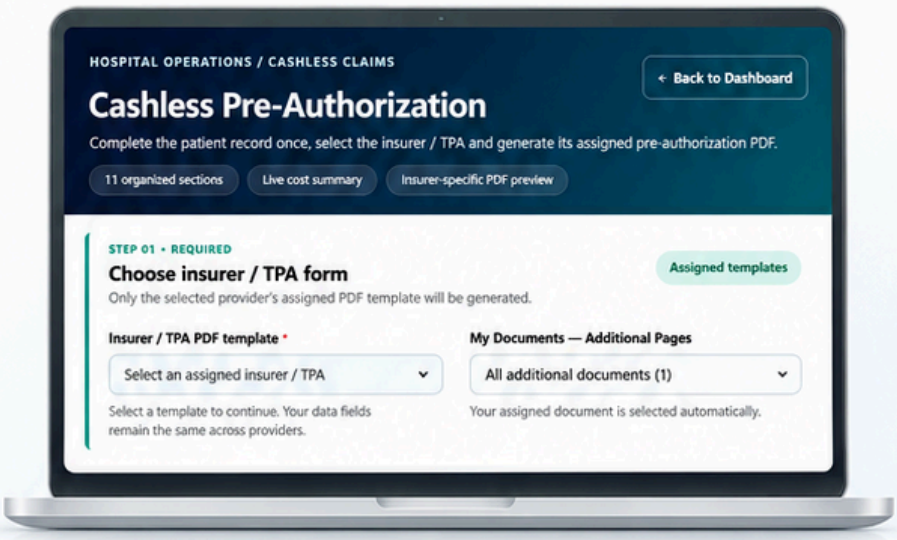
- PDF preview and download
- Designed for hospital cashless desks



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