REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE

POLICY PART - C (Revised)

(TO BE FILLED IN BLOCK LETTERS)

DETAILS OF THE THIRD PARTY ADMINISTRATOR/ INSURER/ HOSPITAL:

a. Name of TPA/ lnsurance company: **MDIndia Health Insurance TPA Pvt. Ltd. (IRDA LICENCENO. 005)**

b. Toll free phone number: **1800-233-4505**

c. Toll free fax: **1800-233-4449**

d. Name of Hospital: _____

i. Address _____

ii. Rohini ID _____

iii. e-mail id _____

TO BE FILLED BY INSURED/PATIENT

A. Name of the Patient _____

B. Gender: ☐ Male ☐ Female ☐ Third Gender

C. Age: (Years) / (Month)

D. Date of Birth: DD/MM/YYYY

E. Contact number: _____

F. Contact number of attending Relative: _____

G. lnsured Card ID number: _____

H. Policy number/Name of Corporate: _____

I. Employee ID: _____

J. Currently do you have any other mediclaim /health insurance: ☐ Yes ☐ No

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 lnsured 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 _____ Days

i. Date of First consultation DD/MM/Y'YYY

ll. 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 and,/or Medical Management, provide _____

i. Route of Drug Administration _____

I: lf surgical, name of surgery _____

i. ICD l0 PCS code _____

J: If other treatment, provide details _____

K: How did injury occur _____

L: ln case of accident _____

i. Is it RTA ☐ Yes ☐ No

ii. Date of injury (DD/MM/YYYY)

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

M. In case of Maternity ☐ G ☐ P ☐ L ☐ A

i. Expected date of Delivery DD/MM/YYYY

DETAILS OF PATIENT ADMITTED

A: Date of admission _____(DD/MM/YYYY)_____

B: Time of admission (HH : MM)

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 _____

ll. Heart disease _____

iii. Hypertension _____

iv. Hyperlipidemias _____

v. Osteoarthritis _____

vi. Asthma./COPD/Bronchitis _____

vii. Cancer _____

viii . Alcohol/Drug abuse _____

ix. Any HIV/ or STD Related ailment _____

x. Any other ailment, give details _____

E. Expected number of Days/stay in hospital provide details _____Days

F. Days in ICU _____Days

G. Room Type _____

H. Per day room rent+ nursing and service charges+ patients diet _____

I. Expected cost of investigation + diagnostic _____

J. ICU charges _____

K. OT charges _____

L. Professional fees Surgeon + 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 of this form

a. Name of the treating doctor _____

b. Qualification: _____

c. Registration number with State code _____

Hospital Seal

Patient / Insured Name

(Must Include Hospital ID)

DECLARATION BY THE PATIENT / REPRESENTATIVE

a. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/T.P.A after the 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 the hospital 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 current hospitalization and the amounts over & above the limit authorized by the Insurer/T.P.A 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 to be false or incorrect I forfeit my claim and agree to indemnify the insurer / T.P.A

e. I agree and understand that T.P.A 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 forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, 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 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:_____e-mail Id(optional)_____

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

Date: _____ Time:_____

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/ lnsurance 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 discharge summary or other documents.

d. The patient 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 responsibility the sole for any delay in offering clarifications

f. We will abide by the terms and conditions agreed in the 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 higher room rent than eligibility choosing separate line of treatment which is not envisaged/considered in package).

h. We confirm that no recoveries would be made from the deposit amount collected from the lnsured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in 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.
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Hospital Seal **Doctors Signature**

Date: **Time:**

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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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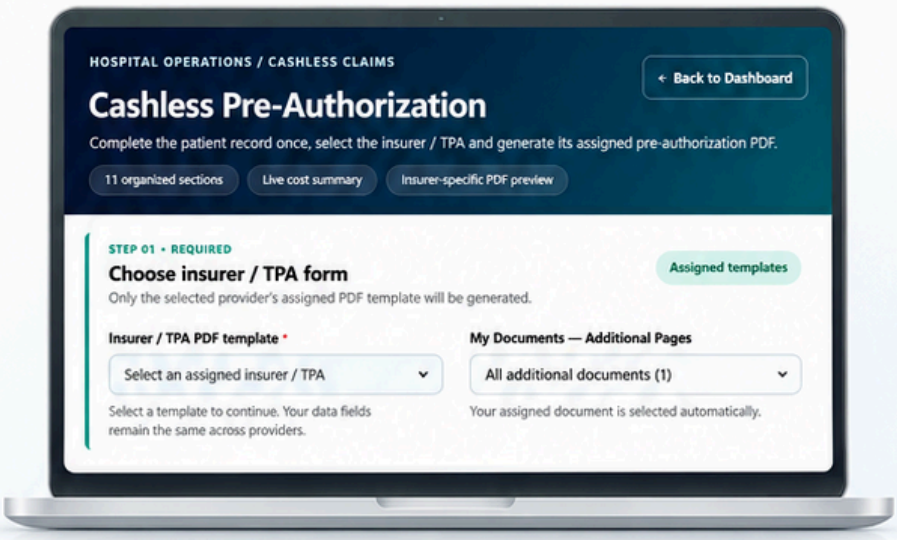

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