PLEASE FAX/SCAN PAGE 1 & 2 ONLY
REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

DETAILS OF THE THIRD PARTY ADMINISTRATOR/INSURER **(To be filled in block letters)**

Name of the Insurance Company

Name of TPA

Toll free phone number

Toll free FAX

TO BE FILLED BY THE INSURED / PATIENT

a) Name of the Patient

b) Gender ☐ Male ☐ Female c) Age: Year (Y Y) Month (M M) d) Date of birth (D D) (M M) (Y Y Y Y)

e) Mobile Number

f) Contact number of attending relative: (Mandatory)

g)Email ID

h) Membership Card Number/ ID Number

In case group health insurance taken by Employer

i) Name of Employer

j) Employee ID

k) Work address

l) Currently do you have any other Mediclaim/Health insurance: ☐ Yes ☐ No If yes, please give policy details

m) Do you have a family physician ☐ Yes ☐ No n) Name of the family physician

o) Contact number

(PLEASE COMPLETE DECLARATION ANNEXED WITH THIS FORM)

TO BE FILLED BY THE TREATING DOCTOR/HOSPITAL

a) Name of the treating doctor

b) Contact number

c) Nature of Illness/ Disease with presenting complaints

d) Relevant clinical findings

e) Duration of the present ailment (Days | Month | Year)

f) Date of first consultation (D D) (M M) (Y Y Y Y)

g) Past history of present ailment if any

h) Provisional diagnosis

ICD 10 Code

i) Proposed line of treatment ☐ Medical Management ☐ Surgical Management ☐ Intensive care ☐ Investigation ☐ Non-allopathic Treatment

j) If Investigation & or Medical Management provide details

k) Route of drug administration

l) If Surgical, name of surgery

ICD 10 PCS Code

m) If any other treatment, provide details

n) In case of accident i. Is it RTA ☐ Yes ☐ No ii. Date of injury D D M M Y Y Y Y iii. Reported 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: ☐ Yes ☐ No vii. If Yes, nature of test and test results

o) How did injury occur

p) In case of Maternity: ☐ G ☐ P ☐ L ☐ A Date of Delivery D D M M Y Y Y Y

Details of the patient admitted

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

b) Time: H H : M M

c) Is this an emergency/planned hospitalization event?

☐ Emergency ☐ Planned

d) Expected no. of days stay in hospital D D

e) Room Type:

f) Per Day Room Rent + Nursing & Service Charges + Patient's Diet Rs.

g) Expected cost for investigation + diagnostics Rs.

h) ICU Charges Rs.

i) OT Charges Rs.

j) Professional fees-Surgeon+ Anesthetist Fees + consultation Charges Rs.

k) Medicines + Consumables + Cost of Implants (if applicable please specify) Rs.

l) Other hospital expenses if any Rs.

m) All inclusive package charges if any applicable Rs.

n) Sum Total expected cost of hospitalization Rs.

Mandatory: Past History of any chronic illness		**If yes, since (month / year)**
☐	Diabetes	M M Y Y Y Y
☐	Heart Disease	M M Y Y Y Y
☐	Hypertension	M M Y Y Y Y
☐	Hyperlipidemias	M M Y Y Y Y
☐	Osteoarthritis	M M Y Y Y Y
☐	Asthma/COPD/Bronchitis	M M Y Y Y Y
☐	Cancer	M M Y Y Y Y
☐	Alcohol or drug abuse	M M Y Y Y Y
☐	Any HIV or STD/Related ailments	M M Y Y Y Y
☐	Obesity related	M M Y Y Y Y
☐	Seizure	M M Y Y Y Y
☐	Stroke/CVA	M M Y Y Y Y

Any other Ailment give details

DECLARATION **(PLEASE READ VERY CAREFULLY)**

We confirm having read understood and agreed to the Declarations attached along with this form

a) Name of the treating Doctor

SURNAME FIRST NAME MIDDLE NAME

b) Qualification

c) Registration No. with State Code

Hospital Seal
(Must include Hospital Registration No.)
and attending Physician's Signature

Patient / Insured's Signature

(IMPORTANT: PLEASE SEE ANNEXURE)

DECLARATION BY THE PATIENT / REPRESENTATIVE

1. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/TPA after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.
2. Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer / TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.
3. All non-medical expenses and expenses not relevant to 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.
4. 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 / TPA
5. 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.
6. 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 statement, suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.
7. I further declare that in respect of the above treatment no benefit is admissible under any other medical insurance scheme other than the one stated by me.

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

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

b) Contact number:_____ c) Patient's / Insured's Signature:_____

HOSPITAL DECLARATION

1. We have no objection to any authorized TPA/Insurance Company official verifying documents pertaining to hospitalization.
2. 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.
3. All non medical expenses , OR expenses not relevant to hospitalization or illness, OR expenses disallowed in the Authorization Letter of the TPA / Insurance Co, OR arising out of incorrect information in the pre-authorisation form will be collected from the patient.
4. 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.
5. The patient declaration has been signed by the patient or by his representative in our presence.
6. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications. We also agree to provide copies of indoor case record and any other relevant medical record if sought by Insurer/TPA
7. We will abide by the terms and conditions agreed in the MOU.

Hospital Seal **Doctor's Signature**

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

1. Detailed Discharge Summary and all Bills from the hospital (Summary bill, Itemised bill).
2. Cash Memos from the Hospitals/Chemists supported by proper prescription, receipts.
3. Pathological Test Reports from Pathologists, supported by note from the attending Medical Practitioner/Surgeon recommending such pathological Tests including X-ray and scan films.
4. Break up of package charges if any
5. KYC document obtained from insured as per AML guidelines prescribed by Government of India.
6. Patient declaration and hospital declaration statement.
7. TDS exemption details if any.

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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

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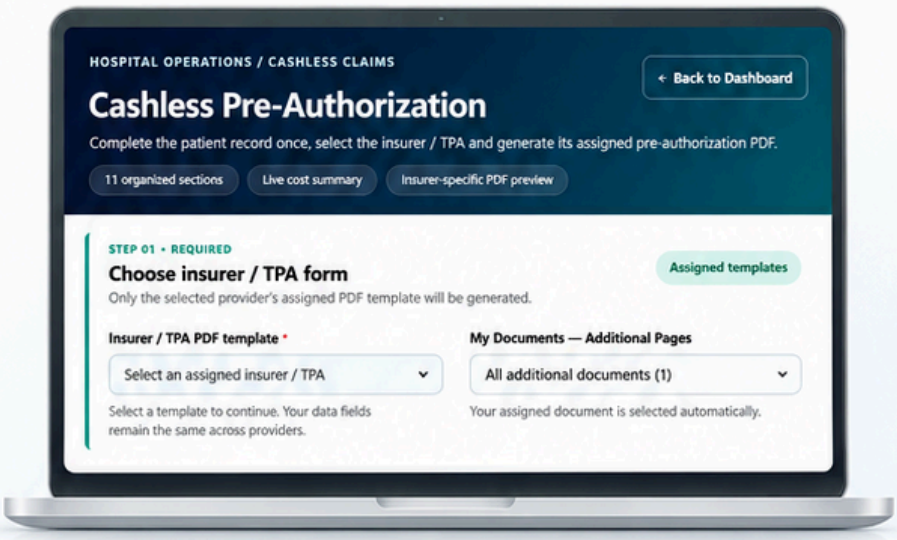

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