Universal Sompo General Insurance
Suraksha, Hamesha Aapke Saath

Request for Cashless Hospitalisation for Health Insurance Policy (PART C)

Email ID: healthserve@universalsompo.com | Cashless Request Form | Toll Free Helpline: 1800 200 4030

Name of the Insurance Company: UNIVERSAL SOMPO GENERAL INSURANCE COMPANY LIMITED

TO BE FILLED BY THE HOSPITAL

a) Name of the Hospital:

b) Address:

c) ROHINI ID:

d) Email ID:

TO BE FILLED BY THE INSURED / PATIENT

a) Name of the Patient:

b) Gender : Male Female Third Gender c) Age: years months d) Date of Birth:

e) Contact number:

f) Contact number of attending relative:

g) Insured card ID number:

h) Policy number / Name of corporate:

i) Employee ID:

j) Currently do you have any other Mediclaim / Helath 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 Insured Patient:

o) Occupation of Insured Patient:

(PLEASE COMPLETE DECLARATION OF 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 i. Date of first consultation:

ii. Past history of present ailment, if any:

f) Provisional diagnosis:

i. ICD 10 Code:

g) Proposed line of treatment: Medical Management Surgical Management Intensive Care Investigation Non allopathic Treatment

h) If investigation & / or Medical Management, provide details:

i. Route of drug administration:

i) If Surgical, name of surgery:

i. ICD 10 PCS Code:

j) If other treatment, provide details:

k) How did the injury occur?

l) In case of accident: i. Is it RTA? Yes No ii. Date of injury: 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 extablish this? Yes No (If yes attach reports)

m) In case of maternity: G P L A i. Expected Date of Delivery:

(IMPORTANT: PLEASE TURN OVER)

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DETAILS OF PATIENT ADMITTED

a) Date of admission: ☐☐ ☐☐ ☐☐☐☐ b) Time: ☐☐ : ☐☐

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

e) Expected no. of days/ Stay in hospital: ☐ Days f) Days in ICU: ☐ Days

g) Room Type :

h) Per Day Room Rent + Nursing & Service Charges + Patient's 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), other hospital expenses, if any : ₹

n) Other hospital expenses if any : ₹

o) All inclusive package charges, if any applicable : ₹

p) Sum Total expected cost of hospitalization : ₹

d) Mandatory : Past history of any chronic illness	If Yes, since(month /year)
☐ Diabetes	☐☐ ☐☐
☐ Heart Disease	☐☐ ☐☐
☐ Hypertension	☐☐ ☐☐
☐ Hyperlipidemias	☐☐ ☐☐
☐ Osteoarthritis	☐☐ ☐☐
☐ Asthma / COPD / Bronchitis	☐☐ ☐☐
☐ Cancer	☐☐ ☐☐
☐ Alcohol/ Drug abuse	☐☐ ☐☐
☐ Any HIV/ or STD Related ailments	☐☐ ☐☐
☐ Any other Ailment, give details:	

DECLARATION

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 (must include hospital ID)

Patient / Insured Name & Signature

DECLARATION BY THE PATIENT / REPRESENTATIVE

1. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Universal Sompo General Insurance Company Ltd 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 Universal Sompo General Insurance Company Ltd 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 Universal Sompo General Insurance Company Ltd not governed by the terms and conditions of the policy will be paid by me. In case any clarification is needed on admissibility of a particular item I shall contact Insurance Company at the Toll Free Number on the reverse of this form.

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 Universal Sompo General Insurance Company Ltd.

5. I agree and understand that Insurer is in no way warranting the service of the hospital & that the Universal Sompo General Insurance Company Ltd 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 forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that, in respect of the above treatment, no benefits are admissible under any other Medical Scheme or Insurance.

7. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Universal Sompo General Insurance Company Ltd.

8. I/ We authorize Universal Sompo General Insurance Company Ltd 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: _____ e) Date ☐☐ ☐☐ ☐☐☐☐ Time: ☐☐ : ☐☐

(IMPORTANT: PLEASE TURN OVER)

HOSPITAL DECLARATION

1. We have no objection to any authorized 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 Universal Sompo General Insurance Company Ltd 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 Universal Sompo General Insurance Company Ltd, OR arising out of incorrect information in the pre-authorisation form will be collected from the patient.
4. WE AGREE THAT 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.
7. We will abide by the terms and conditions agreed in the MOU.
8. 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).
9. We confirm that no recoveries would be made from the deposit amount collected from the insured 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).
10. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, Universal Sompo General Insurance Company Ltd 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	☐☐ ☐☐ ☐☐☐☐	**Time:**	☐☐ : ☐☐

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

1. Detailed Discharge Summary and all Bills from the hospital
2. Cash Memos from the Hospitals / Chemists supported by proper prescription.
3. Receipts and Pathological Test Reports from Pathologists, supported by note from the attending Medical Practitioner / Surgeon recommending such pathological Tests.
4. Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.
5. Certificates from attending Medical Practitioner / Surgeon that the patient is fully cured.

***As per IRDA circular Ref: IRDA/SDD/GDL/CIR/020/02/2013 Anti-Money Laundering /Counter Financing of Terrorism (AML/CFT)-Guidelines for General Insurers. All general insurance companies are required to carry out KYC norms at the settlement stage where claim payout crosses a threshold of ` One lakh per claim. In cases where payments are made to third party service providers such as hospitals, the KYC norms shall apply on the customers on whose behalf service providers act.**

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How PreAuths Pro Works

01 Select assigned insurer / TPA template

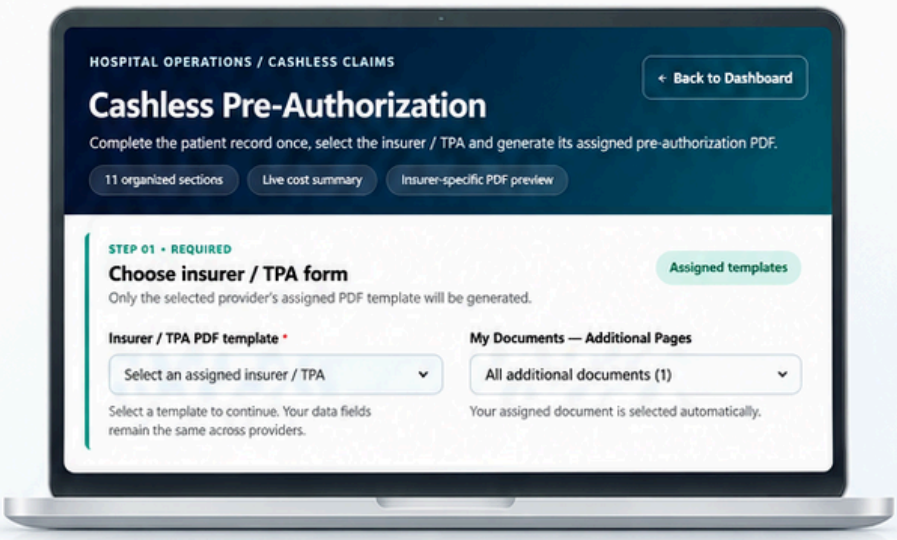
02 Enter patient and hospital details once

03 Preview the generated PDF

04 Download and review before submission

Why hospitals choose PreAuths Pro

- Working mapped templates
- Structured hospital form workflow
- KYC, GIPSA and additional pages support
- PDF preview and download
- Designed for hospital cashless desks



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