Aditya Birla Health Insurance Co. Limited

Preauthorization Form

Request For Cashless Hospitalisation For Medical Insurance Policy

DETAILS OF THE THIRD PARTY ADMINISTRATOR

(To be filled in block letters)

a. Name of TPA/Insurance Company : Aditya Birla Insurance Company Limited
b. Toll free phone number 2 1 4 7 4 8 3 6 4 7 ☐ ☐ ☐
c. Toll free Fax 0 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

TO BE FILLED BY THE INSURED/PATIENT

a. Name of the Patient ☐
b. Gender ☒ Male ☐ Female
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/Health insurance ☒ Yes ☐ No

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k. Company Name: Give details

l. Do you have any family physician☒ Yes ☐No

m. Name of the family physician

n. Contact number if any :

PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THIS FORM

TO BE FILLED BY THE TREATING DOCTOR/HOSPITAL

a. Name of the treating doctor :

b. Contact number:

c. Name of ILLNESS / Disease with presenting Complaints :

d. Relevant clinical findings :

e. Duration of the present ailment : Days

Date of first consultation : Past history of present ailment if any :

f. Provisional diagnosis :

g. ICD 10 Code :

h. Proposed line of treatment : Medical Management Surgical Management Intensive care Investigation Non allopathic treatment.

I. If Investigation &/or Medical Management provide :

j. Route of drug administartion :

k. If Surgical, name of surgery :

l. ICD 10 PCS Code :

m. If other treatments provide details :

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n. How did injury occur : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐