## **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
TO BE FILLED BY THE INSURED/PATIENT
a. Name of the Patient f r i e n d
c. Age 2 5 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 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
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 :
1. ICD 10 PCS Code :
m. If other treatments provide details:

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n. How did injury occur:															