CIN U66010RJ2006PLC029979

IRDAI Registration Number – 137

SHRIRAM GENERAL INSURANCE COMPANY LIMITED
E-8, EPIP, RIICO Industrial Area, Sitapura, Jaipur, Rajasthan – 302022, INDIA
Email: chd@shriramgi.com, Website: www.shriramgi.com

REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE POLICY PART-C

(TO BE FILLED IN BLOCK LETTERS)

DETAILS OF THE TPA / INSURER / HOSPITAL :

a. Name of TPA / Insurance company

b. Toll Free Phone Number

c. Name of the Hospital

i. Address of the hospital

ii. Pin Code | iii. Contact No. | iv. Email ID

v. ROHINI ID | vi. Hospital Registration no.

TO BE FILLED BY INSURED / PATIENT :

a. Name of the Patient

b. Gender ☐ Male ☐ Female ☐ Third Gender

c. Age of the Patient | d. Date of Birth (D D M M Y Y Y Y)

e. Contact Number | f. Alternate Number

g. Insured ID Number | h. Employee ID

i. Policy Number

j. Currently do you have any other Mediclaim / Health insurance? YES ☐ NO ☐

If Yes, i. Company Name

ii. Give details

k. Do you have a family physician? (tick the checkbox) YES ☐ NO ☐

If Yes, i. Physician Name | ii. Contact Number

l. Current Address of insured

m. Insured Occupation

TO BE FILLED BY TREATING DOCTOR/HOSPITAL :

a. Name of the treating Doctor:

i. Contact Number: | ii. Doctor's Speciality

b. Nature of Illness/Disease with presenting complaint

c. Relevant Critical Findings

d. Duration of the present ailment (Days/ Months)

i. Date of First consultation (D D M M Y Y Y Y)

ii. Past History of present Ailment

e. Provisional Diagnosis / Final Diagnosis:

i. ICD 10 Code

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f. Proposed line of treatment (tick the checkbox)

Medical management	Yes	☐	Surgical management	Yes	☐
Intensive care	Yes	☐	Investigation & evaluation	Yes	☐
Non-allopathic (AYUSH)	YES	☐			

g. If investigation and/or Medical Management, Please provide details

h. Route of Drug Administration

i. If surgical, Name Of The Surgery

i. ICD I0 PCS code

j. In case of Injury / Accident

i. How did injury occur?

ii. Date of Injury D D M M Y Y Y Y

iii. Is it RTA: Yes ☐ No ☐ iv. Report to Police Yes ☐ No ☐

v. FIR done Yes ☐ No ☐ vi. MLC done Yes ☐ No ☐

k. Injury /Disease caused due to substance abuse/alcohol consumption Yes ☐ No ☐

l. Lab/ Blood Tests conducted to establish this (if yes, attach report) Yes ☐ No ☐

m. In case of Maternity (If Yes, please select) ☐G ☐P ☐L ☐A

i. expected 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 of admission: AM / PM

c. Is this an emergency/planned hospitalization event: ☐ Emergency ☐ Planned

d. Mandatory Past History of any chronic illness? If yes (Since month / year)

- Diabetes (Type I / Type II)
- Heart disease
- Hypertension
- Osteoarthritis / Arthritis / Gout
- Asthma / COPD / Bronchitis
- Cancer / Tumour
- Alcohol / Drug abuse
- HIV / STD Related ailment
- Any other ailment, give details

e. Expected number of Days/stay in hospital DAYS f. Days in ICU DAYS

g. Room Category (tick the room opted)

Single AC Room	☐	Double Sharing AC	☐	Multi-Bedded AC	☐	Deluxe Room	☐
Single Non-AC Room	☐	Double Sharing Non AC	☐	Multi-Bedded Non AC	☐	ICU/HDU	☐

Any other room type (please specify)

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h. Expected cost of hospitalization : Rs._____

i. Per day room rent + nursing charges : _____ ii. ICU / HDU room charges : _____

iii. Investigation + diagnostic charges : _____ iv. Operation Theatre charges : _____

v. Professional Surgeon fees + Anaesthetist Fees + consultation Charges: _____

vi. Medicines+ Consumables + Implants (If applicable please specify) : _____

vii. Other hospital expenses (if any please specify) : _____

viii. Agreed Network Package charges (If applicable please specify) : _____

DECLARATION BY TREATING DOCTOR (Please Read very carefully) :

We confirm having read understood and agreed to the Declarations of this form.

a. Name of the treating doctor : _____

b. Doctor's Qualification: _____

c. Registration number with State code : _____

Hospital Seal
(Must include Hospital ID)

Patient / Insured Name and Sign

DECLARATION BY THE INSURED PATIENT / REPRESENTATIVE:

a. 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.

b. 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.

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.

Patient's / Insured's Name

Insured's Contact number | E-mail Id

Date: _____ Place: _____

Time:_____ Signature: _____

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DECLARATION BY THE HOSPITAL :

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 be low will be sent to TPA / Insurance 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 the sole responsibility 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 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).

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.

Hospital Seal

Doctor’s Signature

Date: _____

Time:_____