

Pre-Authorisation Form - 'Care' Request for Cashless Hospitalisation for Medical Insurance Policy

- I. To be filled in CAPITAL LETTERS only.
- 2. If there is insufficient space, please provide further details on a separate sheet.
- 3. Please Fax/Scan Page I & 2 only.

Details of the Third Party Administrator
a) Name of TPA/Insurance Company :
b) Toll Free Phone No.: c) Toll Free FAX:
d) Name of Hospital:
i) Address :
ii) Rohini ID :
iii) Email ID :
To be filled by the Insured/Patient
a) Name of the Patient :
(First Name) (Middle Name) (Last Name)
b) Gender: M F Other c) Age: (YY) (YY) 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
i) Company Name :
il) Give Details:
k) Do you have a family physician : Yes No
I) Name of the family physician :
m) Contact Number, if any :
n) Current Address of the Insured Patient :
o) Occupation of Insured Person :
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 : // // (DD/MM/YYYY)
ii) Past history of present ailment if any:
f) Provisional diagnosis:
i) ICD 10 Code :

Non allopathic treatment	g)	Proposed line of treatment : Medical Management	Surgical Management	Intensive care	Investigation											
i) Route of drug administration: If Surgical, marre of surgery:		Non allopathic treatment														
i) if Surgeal, name of surgery: i) ICD 10 PCS Code: j) If other treatments provide details: K) How did injury occur: j) In case of accident: jl is in RTA: yes	h)	h) If Investigation &/or Medical Management provide details :														
i) ICD IO PCS Code: 1		i) Route of drug administration :														
ii) If other treatments provide details:	i)	If Surgical, name of surgery :														
k) How did injury occur : In case of accident: i) Is it RTA :		i) ICD 10 PCS Code:														
i) In case of accident:) Is it RTA: Yes No ii) Date of injury: /	j)	If other treatments provide details :														
iii) Reported to Police: Yes No iv) FIR No: v) Injuny/Disease caused due to substance abuse/alcohol consumption: Yes No wi) Test conducted to establish this: Yes No (If Yes attach reports) m) In case of Maternity: G P L A Date of Delivery: // (DDIMMANNY) Details of the patient admitted a) Date of Admission: // J / (DDIMMANNY) b) Time of Admission: : : ((HHEM)) c) Is this an emergency/a planned hospitalization eventh: Emergency Planned d) Expected no of days stay in hospital: days e) Days in ICU: days f) Room Type: f) Per Day Room Rent + Nursing & Service Charges + Patient's Diet :Rs. g) Expected cost for Investigation + Diagnostics h) ICU Charges j) Professional Fees Surgeon + Anesthetist Fees + Consultation Charges k) Medicines + Consumables + Cost of Implants (if applicable please specify). j) Other hospital Expenses: if any m) All inclusive package charges if any applicable n) Sum Total expected cost of hospitalization Mandatory: Past History of any chronic illness If yes, since (month/year) Diabetes Heart Disease Heart	k)	How did injury occur:														
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a)	Name of the treating doctor:	$\overline{}$											T																	Τ		T	
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De	eclaration by the Patient/l	Rep	rese	nta	ativ	_{re}																		N	lot	to	be	F	axe	d	or	Sca	annec
a.	I agree to allow the hospital to sub the Discharge Summary, before m				doc	ume	nts	pert	aini	ng to	o hos	spita	aliza	atio	n to	the	Insu	rer	/TP/	٩a	fte	rth	e di	sch	narge	e. la	agre	e to	o sigr	no n	n the	e Fir	nal Bill 8
b.	Payment to hospital is governed b bill as per the terms and condition				id cc	onditi	ons	oft	he p	olic	y. In	case	e th	e In	isure	r/T	PA is	s nc	t lial	ble	to	set	tlet	the	hos	pita	al bil	II, I u	ınde	erta	ıke t	o se	ettle the
C.	All non-medical expenses and ex governed by the terms and condit										aliza	tior	n ar	nd t	he ai	mo	unts	OV	er &	ab	OV	e tl	he l	imi	t au	tho	rize	d by	y the	e In	nsure	er/T	TPA no
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 clain and agree to indemnify the Insurer/TPA.																																
e.	. I agree and understand that TPA is the hospital will be of a particular of						he s	ervi	ce o	ofthe	e hos	spita	al &	tha	it the	lns	urer	·/TF	PA is	inı	10	wa	y gu	ara	inte	eing	gtha	ıt th	e se	rvio	ces p	rov	vided by
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h.	. I/We authorize Insurance Compa	ny/TF	Ato	con	tact	me/u	ıs th	nrou	gh n	nobi	le/e	mai	Ifor	an	y upo	date	e on ⁻	this	clair	n.													
	a) Patient's/Insured's Name:																													\perp			
	b) Contact Number:			_													(2)	Ema	il II) (opt	ion	al) :									
	d) Patient's/Insured's Signature:_										D	ate	:						_		Т	Γim	e:_						_				
Н	lospital Declaration																																
a.	We have no objection to any author	orized	d TPA	\/Ins	surai	nce C	Con	npan	y of	ficia	lver	ifyir	ng d	ocu	ımer	nts p	perta	ainii	ng to	h	osp	ital	izat	ion									
b.	 All valid original documents duly of patient's discharge. 	count	ersig	ned	by t	the in	sur	ed/p	atie	ent a	s pei	r th	ie cl	nec	klist I	bel	V WC	vill l	oe se	ent	to	TF	A/Iı	ารน	ran	ce (Con	npar	ny w	/ith	in 7	day	s of the
C.	We agree that TPA/Insurance Co summary or other documents.	mpar	ny wi	ll nc	ot be	e liabl	e to	o ma	ke t	the p	oaym	nen ⁻	t in	the	eve	nt d	of an	ıy d	iscre	ера	nc	y be	etw	eer	n the	e fa	cts i	n th	nis fo	orm	n and	d di	scharge
d.	. The patient declaration has been s	ignec	d by th	ne p	atie	nt or	by ł	nis re	pre	sent	ativ	e in	our	pre	esen	ce.																	
e.	. We agree to provide clarifications	forth	ne qu	erie	s rai	sed n	ega	rding	gthi	s ho	spita	ıliza	tio	n an	id we	e tak	ke th	e sc	ole re	esp	on	sib	ility	for	any	del	lay ir	n off	ferin	ng c	larifi	cati	ons.
f.	We will abide by the terms and co	nditic	ns ag	ree	d in t	the M	101	J.																									
g.	(including additional charges due t	o opt	ing hi	ghe	r ro	om re	ent:	than	elig	ibilit	y/ch	009	sing	sep	arat	e lir	ne of	tre	atm	ent	W	hic	n is r	not	env	'isag	ged/	con	ıside	erec	d in p	oack	age).
h.	 We confirm that no recoveries (including additional charges due t 																																
i.	In the event of unauthorized recorreserves the right to recover the s																															e Co	ompany
	Hospital Seal																				L					Doc	tor'	's Siş	gnat	ure	9		
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