UnitedHealthcare Parekh TPA Pvt. Ltd: Pre-Authorization Form

Fax us on: 022 -28528222 E-mail : nurseline.mumbai @uhcpindia.com

Name of Employee :	Employee Ref. no:	
Company Name :		
Mobile /Res:		Age /Sex:
Email ID:		
Name of patient:	Relation with Employee:	Age/Sex:
Details of treating physician and hospital		
Name of treating physician:		Reg. no:
Qualification:	**Mobile & Clinic No:	
Name of hospital :		Location:
Email ID of Hospital:		
Hospital registration no:	Tax approved:	
Hosp. Tel. no:	Hosp. Fax no:	

Details of diagnosis (Kindly attach Investigation Reports relevant to the diagnosis**)**

**Presenting complaints on Admission :		
**Duration of Ailment:	Previous H/O similar complaints:	
Relevant Clinical Findings:		
TPR/BP:	Other vital symptoms:	
**Date of first onset of symptoms:	Date of first diagnosis:	
**Diagnosis	1º	2º

Mandatory in R.T.A.	**Mandatory in Maternity**	
Under the influence of Alcohol / Drug Abuse -- Yes / No	LMP- EDD-	G___P___A___L___
MLC / FIR Copy **YES / NO** (Kindly Fax the copy)	Type of Delivery: Normal / LSCS -	
Details of Accident:	Indication for LSCS:	
	In case of MTP: **Voluntary / Medical** (USG Report Mandatory)	
Date of Admission:	Expected length of stay	Hospitalization Less than 24 hrs. **No/ Yes**

**Kindly specify the Names of Medicines:

Drugs (names compulsory)	**Inject. (√)**	**Oral (√)**	**Drugs (Names compulsory)**	**Inject. (√)**	**Oral (√)**	**Tick where Applicable**	
Antibiotics							
Anti-inflam. drugs			Steroids			IV transfusions	
Neuro-musc. drugs			Chemotherapy			Radiotherapy	
Cardiac drugs			Sedatives			Blood Transfusion	
Respiratory drugs			Diuretics			Continuous traction	
Others			GI drugs			Intermittent traction	

Names of Investigations supporting to Diagnosis:

****Surgical treatment/ Procedure**:	****Type of Anaesthesia:**

****Estimate Expenses**	
Class of Room	
Room Rate / Day	
Investigation (Attach Breakup)	
Consumables/Pharmacy (Attach Breakup)	
Dr. Visit Charge	
Surgeon Charge	
Anesthetist Charge	
O.T. Charge	
All inclusive Package Charges if applicable	
Total Expenses	

Note: *All the above mentioned fields are required to be filled in Block letters.*Avoid over writing and abbreviations.*Strike out whichever is not applicable*Please provide Discharge summary & Final bill 3 hours prior to discharge of the patient **Mandatory fields

Past History	
****History of :**	**Since**
Alcohol/Drug Abuse – Yes / No	
Tobacco Consumption – Yes / No	
Disease Ailment	
Dyslipidaemia	
Diabetes	
Hypertension	
History of surgery	
History of similar Compliant	
History of related Ailment	

DECLARATION

- I hereby declare that the information provided in the form is true to the best of my knowledge, and authorize UnitedHealthcare Parekh (TPA) to seek any further information from the treating doctor / hospital if needed
- Approval shall be granted subject to the condition that the hospital shall extend full cooperation and provide access patient records related to him / her
- I am aware that the liability of UnitedHealthcare Parekh (TPA) for treatment is limited to facilitating credit and refusal of credit does not amount to rejection of claim
- I undertake that if cashless facility is availed, all original documents, including the discharge summary and investigation reports shall be handed over to the hospital at the time of discharge along with the signed claim form. I am aware that without these documents the claim cannot be processed and I am liable for the same
- I am aware of my health insurance cover and if the hospital expenses exceed the amount, I shall be liable to pay the remainder of the amount at the time of discharge
- I undertake to pay all non-medical expenses incurred in the hospital at the time of discharge
- If the hospitalization comes under any of the policy exclusions & is not reimbursed by the insurance company, I undertake to pay the amount to UnitedHealthcare Parekh (TPA) who have kindly extended the hospital credit facility

****Date : _____ ****Employee Signature:_____**

As a treating physician, I hereby declare that the medical information declared in the form is accurate to the best of my knowledge, if the same is changed/altered, UHCP is not liable to pay the bill to the Hospital for the respective case.

****Date : _____ ****Hospital Stamp (Mandatory) Treating Physician Signature:_____**

Note: Pre-authorization may cause delay if documentation is incomplete or inaccurate	**Kindly send all investigation reports and treatment sheets for all cases, FIR / MLC wherever applicable.**
	Kindly send photo ID of patient with hospital stamp.
	Kindly send complete itemized bill breakup during every enhancement request.