Birla Sun Life Insurance

MD India

Preauthorization Request Form

PART I (To be filled by Policy Owner / Life Assured)

Insured Health Card No (MDID)*: _____ **Policy Number* (in full):** _____

Name of the Policy Owner: _____ Name of the Patient*:_____

Gender: ☐ Male ☐ Female Age:_____ Yrs Relationship with the Policy Owner:_____

Policy Owner / Life assured number to be contacted: Mobile :_____ Tel No:_____

Do you have any Family Physician? ☐ Yes ☐ No.
If 'Yes' Name:_____ Contact No.:_____

PART II (To be filled by Treating Doctor /Hospital)

1. Name and address of Hospital*:_____

_____

2. Hospital phone Number*:_____Fax*:_____Email ID:_____

3. Name of the treating doctor*:_____Qualification*:_____Reg. No._____Contact No.:
4. Name of the referring doctor*:_____Qualification*:_____Reg. No._____Contact No.:

5. The illness / disease / complaint for which hospitalization indicated:_____

6. Relevant Investigation Findings:_____ (attach Relevant Reports)

7. Relevant Clinical Findings:
   B.P.: _____ P/R:_____ Temp:_____CVS:_____
   R.S.:_____CNS:_____ P/A:_____Others:_____

8. Duration of present illness /disease _____ a. Date of 1st Consultation_____ b. Tests done/ treatment taken pre-hospitalization _____

b. Past occurrence of current ailment (If any):_____

9. Provisional Diagnosis:_____ 10. ICD 10 code:_____

11. Proposed Line of Treatment ☐ Medical Management ☐ Surgical Management ☐ Intensive care
☐ Non allopathic ☐ Invasive Investigation

a. If Medical Management, provide details:_____

b. If Surgical, name of surgery:_____ PCS Code_____

c. If invasive investigation, provide details: _____

d. If other line of treatment, provide details _____

12. If an accident, is it RTA?: ☐ Yes ☐ No Date _____ Reported to Police: ☐ Yes ☐ No FIR/MLC enclosed: ☐ Yes ☐ No
If 'No' reason for not reporting to Police :
If not reported, pl furnish name of police station applicable:_____

13. Narrate the circumstances of the accident: _____

_____-

14. Is injury/ disease due to substance abuse/Alcohol consumption: ☐ Yes ☐ No (If 'YES' provide details & enclose relevant test reports)

15. In case maternity: Gravida_____ Para____ Living Children____ Abortion_____ Year(s) of earlier delivery_____

Fetal Death: _____ LMP (Last Menstrual Period): _____ EDD (Expected Date of delivery: _____

16. Hospital admission details:

Type of Admission: ☐ Emergency ☐ Planned ☐ Day care; Probable Date of admission:_____ Time:_____hrs ____ mins

Expected number of days in hospital: Non ICU_____ Days ICU_____ Days Room Type _____

Particulars of Hospital expenses	COST	Past history of Chronic Illness (whether treated or not)	Details	Duration
Room Rent + Nursing and Service charges + patient's diet		Diabetes Mellitus	YES/NO	
ICU charges		Heart disease (IHD/ RHD/ HOCM/ LVF)	YES/NO	
Doctor's daily Visit Charges		Hypertension	YES/NO	
Investigation and diagnostic charges		Dyslipidemia	YES/NO	
Medicines and consumables		Osteoarthritis (knee/ hip)	YES/NO	
Operation theatre charges		Asthma/COPD/ Chronic Bronchitis	YES/NO	
Surgeon charges		Cancer	YES/NO	
Anesthesia / Anesthetist charges		HIV/STD related ailments	YES/NO	
If Implant to be used: details of implant (name, manufacturer)		Habits: ☐ Alcohol ☐ Smoking ☐ Smokeless Tobacco		
Cost of implant		Any other ailment provide details:		
Package rate (if applicable)				
Other charges				
Service Tax				
Total Cost of Hospitalization				

PART III (Other Insurance Details of Policy Owner / Life Assured

1. Any other relevant information:_____

2. Are you at present covered under any other similar type of insurance (Individual or Group Health Insurance, etc.) with BSLI or other Insurance Company? ☐ Yes ☐ No. If yes, please provide details:

Policy No	Name of insurance company	Individual /Group Health Insurance	Policy Issue Date	Sum Assured

3. Other Preauthorization request / Reimbursement claim details under Policy/ies with BSLI or other Company (Current / past):

Insurance Company	Ailment	Admission date	Preauthorisation / Reimbursement claim	Date of decision	Decision (Pay/Reject)	Amount

PART IV (Declaration Of The Policy Owner/Life Assured)

I have "No Objection" and hereby authorize BSLI/ MDIndia to obtain details of my treatment / collecting medical records or seek additional/related information pertaining to my claim from the Hospital/Nursing Home. I acknowledge and agree that the information provided by me with respect to complaints and past illnesses are true, complete and correct to the best of my knowledge and belief. I understand and agree that in the event that any of the above details are found to be untrue or incorrect, MDIndia /BSLI (Company) has the right to refuse my preauthorization request or where the authorization has already been given, refuse payment in respect of the same. I further understand and agree that I shall be responsible and agree to bear the hospitalization and related expenses should this authorization become null and void due to wrong and/or misleading and/ or incorrect information regarding the duration of the ailments and/or of other historical information regarding my/ patient's health status.

_____ _____

Signature of Policy Owner with date Signature of Patient / Life Assured with Date

PART IV (Declaration Of The Hospital Authorities)

BSLI / MDIndia will not be held liable for the payment in the event of any discrepancy between the facts presented at the time of admission & in final documents submission. All non medical expenses and expenses not relevant to the illness which is not payable by BSLI/MDIndia should be directly collected from the patient. We have no objection to any authorised TPA/ Insurance Company official / authorised representative verifying documents pertaining to hospitalisation.

Signature of treating Doctor (not RMO/ Casualty officer):_____ Seal of the Hospital

Instructions:

1. The Company will not be held liable for payment in the event of any discrepancy in information provided by the hospital at the time of admission and network settlement (in final document submission)
2. If any details provided are insufficient/ incorrect, there may be delay/ denial of preauthorization (cashless) request.
3. Additional Information may be called for before authorizing for cashless facility
4. For cases other than emergencies, please send us the investigation reports and consultation papers along with pre authorization request.
5. Denial of authorization does not mean denial of treatment and does not in any way prevent LA from seeking necessary medical attention or hospitalization. Hence, irrespective of the TPA's decision on the pre authorization request, it is advisable to LA to avail health treatment as recommended by the treating doctor.
6. Any change in the diagnosis/ treatment plan / length of stay should be intimated to the Company before discharge of the life assured and approval of the same shall be subject to Policy terms and conditions.
7. All the bills and claim form have to be duly signed by the patient before getting discharged.
8. Any request for authorization/enhancement made by the hospital after discharge of the life assured will not be considered.