RELIANCE GENERAL INSURANCE

reliancegeneral.co.in
022 4890 3009 (Paid)
74004 22200

Corona Kavach Policy, Reliance General

Pre-Authorisation Form Part - C

Request for Cashless Hospitalisation for Health Insurance Policy

(To be filled in BLOCK LETTERS)

Go digital & use Reliance Provider Portal - https://provider.reliancegeneral.co.in/.
Adopt ease of sending pre-auth through provider portal. No hassle of filling up multiple pages of pre-auth form.

DETAILS OF THE THIRD PART ADMINISTRATOR/INSURER/HOSPITAL

1) Name of TPA/Insurance Company: Reliance General Insurance Co. Ltd., RCare Health

2) Toll free Number: 18003009 3) Toll Free Fax No.: 180030103001

Name of Hospital: Star Hospital Hospital ID:

Hospital email ID: tpa@starhospital.co.in BOHINI ID:

Do Insurance Yourself
A Smart App by Reliance General Insurance
available on App Store Google play

Click and download: http://onelink.to/ep5mb4 .
Single Mobile app for multiple transactions; it's easier to track the pre-auth status, submit pre-post claims through Self-i & much more.

TO BE FILLED BY INSURED/PATIENT

a) Name of the patient: Buddhram

b) Gender: ☑ Male ☐ Female ☐ Third Gender c) Age 47 years _____ Months

d) Date of birth: d d m m y y y y

e) Contact number: 7701938988

f) Contact number of attending relative: g) Insured Card ID number: RAKAS2500000414

h) Policy number/Name of Corporate: 130432529843000034

i) Employee ID: IAB02005

j) Currently do you have any other Mediclaim /health insurance ☐ Yes ☑ No I). Insurer Company Name:

ii). Give Details:

k) Do you have a family Physician ☐ Yes ☑ No

l) Name of the Family Physician: m) Contact number, if any:

n) Current Address of insured patient:

o) Occupation of Insured patient

(Please complete Declaration of this form on page 3

TO BE FILLED BY TREATING DOCTOR/HOSPITAL

a) Name of the treating Doctor: Dr. SB Yadav

b) Contact number: 7300484848

c) Nature of Illness/Disease with presenting complaint: fever high pain chills cough + vomiting and

d) Relevant Critical Findings: BP 110/70 mmhg - P 114/m - Temp 102.8°F, urinary conti

e) Duration of the present ailment: 3-4 Days

i) Date of First consultation:

ii) Past history of present ailment, if any: NAD

Please courier documents to the below address:
RCare Health: Reliance General Insurance, No.1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block, Krishe Sapphire, Madhapur, Hyderabad 500081.
Email: rgicl.rcarehealth@relianceada.com.

f) Provisional diagnosis APL i) ICD 10 code

g) Proposed line of treatment

☐ i) Medical Management ☐ ii) Surgical Management ☐ iii) Intensive care ☐ iv) Investigation

☐ v) Non-allopathic treatment ☐ vi) Home care Treatment

h) If investigation/or Medical Management, provide details

i) Route of Drug Administration IV, IM, orally

I) If surgical, name of surgery i) ICD 10 PCS code

J) If other treatment, provide details

k) How did injury occur

l) In case of accident

i) Is it RTA: ☐ Yes ☑ No ii) Date of Injury d d m m y y y y iii) Reported to Police ☐ Yes ☑ No

iv) FIR No v) Injury /Disease caused due to substance abuse/alcohol consumption ☐ Yes ☑ No

vi) Test conducted to establish this (if yes, attach report) ☐ Yes ☑ No

m) In case of Maternity ☐ G ☐ P ☐ L ☐ A

i) expected date of Delivery

DETAILS OF PATIENT ADMITTED

a) Date of admission 13/08/25

b) Time of admission 16:41

c) Is this an emergency/planned hospitalization event ☑ Emergency ☐ Planned

Mandatory Past History of any chronic illness If yes (since month/year)

S.No	Documents	
1	Diabetes	M M YY
2	Heart disease	
3	Hypertension	
4	Hyperlipidemias	
5	Osteoarthritis	
6	Asthma./COPD/Bronchitis	
7	Cancer	
8	Alcohol/Drug abuse	
9	Any HIV/ or STD Related ailment	
10	Any other ailment, give details	

d)	Expected number of Days/stay in hospital	2-4	Days
e)	Days in ICU		Days
f)	Room Type	RT	
g)	Per day room rent+nursing and service charges+ patients diet	₹ 10,000/-	
h)	Expected cost of investigation +diagnostic	₹ 5000/-	
i)	ICU charges	₹	
j)	OT charges	₹	
k)	Professional fees Surgeon +Anesthetist Fees + consultation Charges	₹ 4000/-	
l)	Medicines + Consumables + Cost of Implants (if applicable please specify)	₹ 10,000/-	
m)	Home care Treatment expenses	₹	
n)	Other hospital expenses if any	₹	
o)	All-inclusive package charges if any applicable	₹	
p)	**Sum Total expected cost of hospitalization**	₹ 29,000	

DECLARATION (Please read very carefully)

We confirm having read understood and agreed to the declarations on the reverse of this form

a.	Name of the treating doctor	Dr. SB Yadav
b.	Qualification:	MBBS, MD
c.	Registration number with State code	49623

STAR HOSPITAL BHIMAVARAM BILLING

Hospital Seal (Mention Reliance Hospital ID)

Patient/Insured Name and Sign

DECLARATION BY THE PATIENT / REPRESENTATIVE

a. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/T.P.A 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/we hereby authorize RGICL/It's representatives to seek further information from myself/hospital/treating doctor/my workplace if deemed necessary by RGICL w.r.t. any information of my treatment/hospitalization/claim.

Please courier documents to the below address:
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Email: rgicl.rcarehealth@relianceada.com.

h. I hereby understand that the documents have to be submitted to RCARE health directly and the TAT for claim would be considered from the date of submission of all required documents by RGICL at their claim servicing address as mentioned in the policy/certificate.

I. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer/ TPA.

j. I/We authorize Insurance Company/TPA to contact me/us through mobile/email for any update on this claim

a) Patient's / Insured's Name Buddhram

b) Contact Number 7701938988 c) E-mail Id (optional) _____

d) Patient's / Insured's Signature _____ Date 13/08/2025 Time 16:41

HOSPITAL DECLARATION

1. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.
2. All valid original documents duly countersigned by the insured/patient as per the checklist below will be sent to TPA/ Insurance Company within 7 days of the patient's discharge.
3. All non-medical expenses, OR expenses not relevant to hospitalization or illness, OR expenses disallowed in the Authorization Letter of the Insurance Company, OR arising out of incorrect information in the pre-authorisation form will be collected from the patient.
4. 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.
5. The patient declaration has been signed by the patient or by his representative in our presence.
6. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
7. We will abide by the terms and conditions agreed in the MOU.
8. 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).
9. 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).
10. 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.
11. Any change in Diagnosis/Treatment plan should be intimated before discharge of patient.
12. If clinical details provided are insufficient, Insurer/TPA may delay the authorization or denial for cashless access.
13. As per IRDAI any claimed amount above 1 lac, Pan card of the Insured/Policy holder/Proposer/Guardian and below 1 lac, Photo identity proof is mandatory.

Hospital Seal _____ Doctor Signature DR. S. B. YADAV MBBS, MD RMC - 49623/21694

Date: 13/08/2025 Time: 16:41

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM:

1. Detailed discharge summary and all bills from the hospital
2. Cash memos from the hospitals/chemists supported by proper prescription.
3. Receipts and pathological test reports from pathologists, supported by note from the attending medical practitioner/surgeon recommending such pathological tests.
4. Surgeon's certificate stating nature of operation performed and surgeon's bill and receipt.
5. Certificates from attending medical practitioner/surgeon that the patient is fully cured.

An ISO 9001:2015 Certified Company

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RGI/MCOM/CO/CORONA-KAVACH -PRE AUTHORIZATION- CLAIM /Ver. 1.0/300720.