Star Health and Allied Insurance Co. Ltd.
Regd. & Corporate Office
#1,New Tank Street,Valluvar Kottam High Road,Nungambakkam, Chennai – 600 034
phone : 044-28288800 Fax : 044-28260062 Website : www.starhealth.in
Toll Free No. 1800 425 2255
Board No. 044-28263300

Pre-Authorisation Request Form

PART -1 (TO BE FILLED BY THE INSURED)

Policy No I.D. No

Name of the Patient Age Yrs. Sex: M/F

Patient Tel. No. (Office): Fax: Mobile No. : Res. No

If Corporate, Name of the Employee: Corporate Name:

Relation to the Proposer/Employee(In case of Corporate)Spouce Child Parent Siblings,Please Specify(Others):

Name of the Family Physician Tel. No Mobile No. :

Your Claim may be rejected, if these inf's are not given.

PART – II (TO BE FILLED BY THE HOSPITAL)-ALL COLUMNS ARE COMPULSORY

A.Hospital and Treating Docotr details:

Name of the Hospital/Nursing Home Tel. No

Address of the Provider

Name of Treating M.O/Consultant Tel. No Mobile No:

B.Clinical Data

Presenting Symptoms with duration

Clinical Findings (Present illness)

General Examination: CVS / RS / GI / CNS/PA / PR / PV / OTHERS

C.MEDICAL HISTORY

Sl.No	Particulars	Yes/No	If yes, since	If yes, Remarks
1	Diabetes			
2	Hypertension			
3	Heart Disease			
4	Br. Asthma			
5	COPD			
6	Osteo Arthritis			
7	Cancer			
8	Glaucoma / cataract			
9	Any other Pre Existing Disease			
10	STD related Diseases			

H/O past illness relevant to present illness

Whether present illness is a complication of any pre-existing disease /operation/past diseases

D.Any Evidence of Alcohol / Drug addiction & intoxication

E.Positive findings of investigation done

F.Provisional Diagnosis

G.Pain of Treatement

In case of **Marernity**,No. Of Live Children OBSTETRICAL HISTORY LMP E.D.D

Probable duration of stay: Room ICU/Reason Total

(Attach Doctors First Prescription) Signature of Treating M.O with seal Qualification

H.Admission and Financial details:

Admission: Planned/Emergency Date of Admission Time of Admission Class of Accommodation

Cost Estimation Break-ups: Room Rent Investigation Surgeon Fees Doctor Fees

Consumables/Implants Packages Approximate Total Exps

Whether Telephonic intimation given to Star Health Yes/No If Yes, Date Time

Signature of Billing Head Stamp of Hospital Date Time

PART – III (TO BE FILLED BY THE INSURED) – INSURED CONSENT / AUTHORISATION

I Here by declare that i am having Medical Insurance Policy since without any break from Insurance Company. My previous year Policy No from period to issued by office.

Consent by the patient / insured / beneficiary:

I/We have NO OBJECTION to STAR officials visiting hospitals/nursing home to verify details of treatement/obtain copies of necessary documents from the hospital/nursing home. I/We have provided the information to the best of my knowledge. I/we agree to pay cost of hospitalization, if authorization given by STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED becomes null and void due to wrong and incorrect information regarding the duration of ailments and past history.This content is also final discharge for hospitalization part of the claim where it has effected the payment. I reserve the right to submit pre and post hospitalization or other claims seperately as and when required and as per the policy terms and condtions

Save

Signature of the Patient / Relative(s)