MEDI ASSIST INDIA PRIVATE LTD

PLEASE FAX PAGE 1 ONLY **TOLL FREE FAX: 1800 425 9559**

REQUEST FOR CASHLESS HOSPITALISATION / CLAIM FORM FOR MEDICAL INSURANCE POLICY

To be filled in block letters in black ink only / Please fill all the Columns Completely

To Be Filled By the Insured /Patient

1. Name of Patient: **Contact Number :**	2. Age	3. Sex : -- (M/F)
4. TPA ID No:	5. Policy No / Corporate	6. Employee ID:
7. Any other Cancer/Medical/Health Insurance etc - Give Details		

To Be Filled By the Treating Doctor/Hospital

8 (a) Name of treating Doctor:& Mobile No.			
8 (b) Doctor's Qualification		8 (C) Dr. Reg. No:	
9. Nature of ILLNESS / Disease with presenting complaints			
10. Duration of the present ailment			
11. Earlier history of the present ailment if any			
12. Relevent clinical findings			
13. Provisional Diagnosis			
14. Proposed line of treatment:		(Investigation/ Intensive Care / Medical Management / Surgical Managemet)	
14 (a) If 'Investigation' &/or 'Medical Management', please provide detailed line of treatement with route of drug administration			
14 (b) If 'Surgical' name the Surgery to be conducted and its details			
14 (c) If **Chemotherapy** – which cycle ?		14(d) If **Radiotherapy** – how many fractions?	
14 (e) For any other treatement, please furnish details			
15. ICD 10 PCS Code			
16. In case of 'Injury': **16 (a) How did injury occur?**			
16 (b) Was it intentional self injury? Attempted Suicide?	(Y/N)	16 (c) Is it Road Traffic Accident?	(Y/N)
16 (d) Was it under influence of Alcohol	(Y/N)	16(e) Breath Analyser Report attached	(Y/N)
16 (f) Was it under influence of Drugs	(Y/N)	16 (g) Date of Injury	
16 (h) FIR / MLC Attached	(Y/N)	16 (i) If no MLC done - reason thereof	
17. In case of Maternity: (a) G P L A		17 (b) LMP	
18 (a) Probable Date & Time of Admission		18 (b) Is this **Planned** or **Emergency** Hospitalisation?	**Planned/Emergency**
18 (c) Expected No. Of days of Hospital Stay		18(d) Class of Accommodation	
18 (e) Details of Hospitalisation Expenses	**Amount**	19. History of Smoking if any	
i) Room Rent (Per day)		20. Past History of any Chronic Ailment - **MANDATORY**	
ii) Nursing Charges (Per day)		**Ailment** / **Yes/ No** / **Duration – dd/ mm/ yy**	
iii) Patient Diet Charges		a) Diabetes	
iv) Investigation / Diagnostics Charges		b) Hypertension	
v) Surgeon/ Assistant/ Anaesthetist/ Consultant Charges		c) Heart Diease	
vi) Medicine & Consumables Excluding Implants/ Stents		d) Br. Asthma/ COPD	
vii) Implants/ Stents & High Value Consumables		e) Osteo Arthritis	
viii) OT Charges		f) Cancer	
ix) Other Charges (Please Specify) :		g) Any other	
		h) Any hostory of Alcohol abuse	**Yes/ No**
		i) Any HIV/ STD related ailment	**Yes/ No**
If Package charges: (1) Primary Surgery:		j) Whether the Defect is Congential Internal/ External?	Internal/External
(2) Second Surgery:		k) Any other relevent information:	
Total Estimated Expenses			
We confirm having read, understood and agreed to the Declarations on the reserve of this form.			
Treating Doctor Name & Signature	Hospital Seal	Hospital ID Number	Name & Signature of the Patient/Insured

Save

HOSPITAL DECLARATION

1. We have no objection to any authorized TPA official verifying documents pertaining to hospitalization.
2. All valid original documents **duly counttersigned by the insured / patient** as per the checklist below will be sent to TPA with in 7 days of the patient's discharge.
3. All non-medical expenses and expenses not relevent to hospitalization or illness those are not payable by TPA will be collected from the patient.
4. **WE AGREE THE TPA WILL NOT BE LIABLE TO MAKE THE PAYMENT IN THE EVET OF ANY DISCREPANCY BETWEEN THE FACTS IN THIS FORM AND DISCHARGE SUMMARY**
5. The patient declaration has been signed by the patient or by his representative in our presense.
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.

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Hospital Seal Doctor's Signature

DECLARATION BY THE PATIENT / REPRESENTATIVE

1. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the T.P.A after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.
2. Payments to hospital is governed by the terms and conditions of the policy. In case Medi Assist is not liable to settle to the hospital bill, I take complete responsibility to settle the bill.
3. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by **T.P.A** will be paid by me. In case any clarification is needed on admissibility of a perticular item I shall contact **T.P.A Toll Free Telephone Number 1800 425 9449**
4. I hereby declare to abide by the rules and regulations 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 the indemnify T.P.A
5. I agree and understand that **T.P.A** is in no way warranting the service of the hospital & that Medi Assist is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.
6. I hereby warrent 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 concelment, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further decalre that, in respect of the above trearment, no benefits are admissible under any other Medical Scheme or Insurance.

Patient's Insured's Name Patient's/ Insured's Signature _____

Phone No:

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

1. Detailed Discharge Summary and all Bills from the hospital duly countersigned by the Insured/ patient.
2. Cash Memos from the Hospital / Chemists supported by proper prescription.
3. Receipts and Pathalogical Test Reports from Pathologists, supported by note from the attending Medical Practitioner / Surgeon recommending such pathological Tests.
4. Surgeon Certificate stating nature of operation performed and Surgeon's Bill and Receipt.
5. Certificates from attending Medical Practirioner / Surgeon that the patient is fully cured.
6. supporting Bills and Stickers for Implants & Stents.