



TTK HEALTHCARE TPA PRIVATE LIMITED
PRE-AUTHORIZATION REQUEST FORM
PART – I (TO BE FILLED IN BY THE INSURED)

Form No 7
Version 5 / Dec 06

Policy No :			TTK ID Card No :		
Pt. Name			Age		Sex
Occupation			Designation		
Emp. ID			Corporate Name		
Address and Tel. No. of Insured					Signature of Insured
PART – II TO BE filled in by the Doctor / Hospital in utmost Good Faith					
Chief Complaints					
Duration of ailment			Any past illness Relevant to present ailment		
Clinical findings					
Provisional Diagnosis					
Plan of Treatment	Medical	Treatment relating to (Please fill details below)		a. Maternity b. Trauma c. Alternative Medicine	
	Surgical				
Name and address of the Hospital			Hospital Tel No.		
			Hospital Fax No.		
Name of TPA Coordinatore			Empanellment No.		
Likely Date & Time of Admission			Past history of any chronic illness If Yes Duration Mandatory SINCE ? YEARS		
Is this a emergency / a planned Hospitalization Event ?			a)Diabetes :		
Expected no. of days stay in Hosp			b) Hypertension :		
Class of accommodation			c) Heart Disease :		
Per Day Room Rent + Nursing & Service Charges + Patient's Diet			d) Br. Asthma :		
Expected cost for Investigation + Medicines + Consumables & other Hospital expenses if any & OT Charges			e) COPD :		
Doctor's = Surgeon + Asst Surgeon + Anesthetist Fees + Visit Charges			f) Osteo Arthritis :		
All inclusive package charges if any applicable			g) Cancer :		
Any separate cost of Implants (if applicable please specify)			h) Any histiry of Alcohol abuse / intoxication :		
SUM TOTAL EXPECTED COST OF HOSPITALIZATION Rs :			i) Any HIV or STD / Related ailments :		
* MANDATORY IN MATERNITY Menstrual History Obstetric History G_____P_____A_____L_____ LMP : _____ EDD : _____ NORMAL / LSCS Expected		* MANDATORY IN RTA H/O ALCOHOL ABSUE MLC / FIR COPY CIRCUMSTANCES		* MANDATORY FRO CALL CASES Name of the treating Doctor Signature Mobile No. Hospital Stamp Date	

Consent by Patient/Insured/Beneficiary: I/We have no objection to TTK officials visiting the Hospital/Nursing Home to check the details of treatment. TTK is authorized to collect documents pertaining to my treatment from the Hospital/Nursing Home. I/We have provided the necessary information accurately to the best of my knowledge. I/Weagree to pay the cost of the hospitalization if authorization given by TPA becomes null and void due to wrong and incorrect information regarding the duration of ailments.