

**MDINDIA HEALTHCARE SERVICES (P) LTD.**  
**REQUEST FOR PRE-AUTHORIZATION**

FOR CASHLESS ASSISTANCE – TOLL FREE NO: 1800 233 4505

FAX NO:020-2530 0030

MOBILE NO: 093 2644 2922

**PART I : TO BE FILLED BY PATIENT/RELATIVE/ATTENDENT :**

**DATE:**

Name of Patient:	Age:      Yrs	Sex: (M/F)	Name of Proposer:
Insurance Company:NIA/NIC/OIC/UIIC/RELIANCE/OTHER	Policy Since:		MDI ID No : <b>MDI5-000</b>
Policy No: [Kindly enclose current & previous year policy copy]	Emp. No :		Corporate Name :
Previous Claim/Hospitalization: (Yes/No)	,then Date & Diagnosis:		

**PART II: TO BE FILLED BY TREATING DOCTOR:**

Presenting Complaints :	Duration:		
Clinical Findings BP: / mm of Hg	Pulse: /min	CVS:	CNS: RS:

**PROVISIONAL DIAGNOSIS:**

Treatment: Conservative: Oral:	I.V:
Surgery:	Grade:Minor/Intermediate/Major/Supra Major.
Anaesthesia: GA/LA/SA/EA.	

**INVESTIGATION FINDINGS CONFIRMING THE DIAGNOSIS:[Kindly enclose reports]**

PAST HISTORY	YES/NO	DURATION	PERSONAL HISTORY WITH DURATION( YES/NO)
Hypertension			1] Alcoholism/Smoking/Tobacco Chewing/Gutkha/Drugs.
Diabetes			2]History of past illness relevant to present illness .
Cardiac Ailments			3]Present ailment is a complication of pre-existing disease/injury/surgery?
Asthma/COPD			4]Is the disease/injury self inflicted?
Osteoarthritis			MANDATORY: A] In case of RTA – 1]MLC / FIR [Kindly enclose the copy]
Cancer			2]Is the injury caused directly or indirectly due to use of alcohol / drugs?
HIV I & II			3]Cause of Injury sustained: 4]Date & Time:
Others			B]In case of Maternity- 1]LMP: 2]EDD: 3]G P A L

**PART III: TO BE FILLED BY HOSPITAL:**

Name of Hopital:	Room+Nursing Charges =Rs	/day
Location: Provider Code:	ICU+Nursing Charges =Rs	/day
City: Fax No: Date of Admission:	Consultation Charges =Rs	/day
Phone No: Duration of Stay:	Surgeon+Anaest Charges =Rs	
Name of TPA Co-ordinator: Class of Accomodation:	Surgery+O.T. Charges =Rs	
Mobile No: Hospital E-Mail ID:	Investigation Charges =Rs	
Name of Ttreating Doctor:	Medicine/Implant Charges =Rs	
Mobile No: E-Mail ID:	Total Charges =Rs	

**HOSPITAL DECLARATION:** MDIndia will not be held liable for payment in the event of any discrepancy between the facts presented at the time of admission & in final documents submission.

Signature of Treating Doctor:

Registration No:

Rubber Stamp of Hospital:

**INSURED [PATIENT] CONSENT:** I have “No Objection” to MDIndia obtaining the details of my treatment / collecting documents & hereby authorize MDIndia to Settle the hospital bill and reimburse itself / receive the amount from my claim receivable from the insurance company. I/ We agree to pay the cost of Hospitalization if authorization given by TPA becomes null and void due disclosure of wrong and incorrect information regarding the nature, duration & past history of all ailments. This consent is also final discharge for hospitalization part of the claim where it has affected the payment. I reserve the right to submit Pre/post hospitalization claims seperately and when required as per the policy terms and conditions.

Patient's Signature:

E-mail ID:

Mobile No: