UNITEDHEALTHCARE INDIA (PVT.) LTD.

PRE-AUTHORIZATION FORM FOR HOSPITALIZATION

To be faxed back to 022 2491 46 46 e-mail:nurselinemumbai@uhcindia.com

Credit may be denied if the details in the form is found incomplete or inaccurate

Name of employee						Employee Tel No.	
Company name							
Off Tel: Fax:			Mobile:			Res Tel:	
Name of Patient						Relation:	
Address to which claim form cheque to be Sent:							
Details of Treating Physician and hospital							
Name of treating physician						Reg No.	
Qualification			Mobile			Tel. Clinic	
Name of Hospital						Location	
Hospital registration no.				Tax approved Yes/No/Don't Know			
Hosp. Tel No.				Hosp. Fax No.			
Details of diagnosis							
Detailed-diagnosis	1°			2°		3°	
Symptoms on admission							
Date of first onset of symptoms				Date of first diagnosis			
For maternity only	LMP			EDD			
Treatment proposed(please write Yes where applicable)							
Date of addmission				Expected length of stay		Less than 24 hrs. (Yes/No)	
	Inject(Yes/No)	Oral(Yes/No)		Inject(Yes/No)	Oral(yes/No)		
Antibiotics			Steriods			IV transfusions	
Anti-inflam. Drugs			Nutrients			Chemotherapy	
Neuro-musc. Drugs			Sedatives			Radiation	
Cardiac drugs			Diuretics			Blood & comp.	
Respiratory drugs			GI drugs			Continuous traction	
Other*(please specify)			*			*	
Procedures (describe)							
Surgical treatment(describe)							
Anesthesia							
Past History(Please specify duration)							
	Since		(Please provide details for below if applicable)				Since
Hypertension			History of surgery				
Dyslipidaemia			History of similar complaints				
Diabetes			History of related ailments				
Estimate of expenses							
Room rent/day	Rs.		Pharmacy	Rs.		Surgeon charge	Rs.
Investigations	Rs.		Physician charge	Rs.		Anesthetist charge	Rs.
Consumables	Rs.		Other	Rs.		TOTAL	Rs.

DECLARATION

- **I hereby declare that the information provided in the form is true to the best of my knowledge, and authorize UnitedHealthcare India to seek further information from the treating doctor/hospital if needed.**
- **I am aware that the liability of UnitedHealthCare for treatment is limited to facilitating credit and refusal of credit does not amount to rejection of claim.**
- **I undertake that if cashless facility is availed, all original documents including the discharge summary and investigation reports shall be handed to hospital at the time of discharge along with the signed claim form. I am aware that without these documents the claim cannot be processes and liable for the same.**
- **I am aware of my health insurance cover and if the hospital expenses exceed the amount,I shall be liable to pay the remainder of the amount at the time of discharge.**
- **I undertake to pay all non-medical expenses incurred inthe hospital at the time of discharge.**
- **If the hospitalization comes under any of the policy exclusions & is not reimbursed by the insurance company, I undertake to pay the amount to United healthcare India who have kindly extended the hospital credit facility.**

Date **Employee Signature**

- **As treating physician,I hereby declare that the medical information declared in the form is accurate to the best of my knowledge.**

Date **Hospital stamp** **Treating Physician Signature**

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