

alankit HEALTH CARE LTD.

Regd. Office: 205-208, Anarkali Complex, Jhandewalan Extn. New Delhi – 110055
 Corp. Office: Alankit House, 2E/21 Jhandewalan Extn., New Delhi – 110055
 Phone: 42541256-60, Fax: 42541266-67, E-mail: health@alankit.com

PRE-HOSPITALIZATION FORM

1. Alankit Card No:

Insurer's Name:

Policy No:

Sum Assured

Cum. Bonus

Previous Coverage Details

Fresh / Renewal

Name of the Insured:

Contact No. Office:

Residence

Mobile

Relationship with Patient(Self/Spouse/Son/Daughter/Parents/Others)

Age:

Sex:

Contact No:

Name of the Patient:

Name of the Family Doctor:

Any claim in past(If yes, Provide Particulars of same)

2. Hospital Particulars:

Name & Address of the Hospital:

Regn. No:

IPDNo.

Name of the Contact Person of Hospital:

Designation:

Contact No./Mobile

Individual/Corporate/Group:

Employee Code

Contact No.

Presenting Complaints		Duration	Please attach Doctor's Ist Prescription details of Inves. & Treatment	

Past History Relevant to the Presenting Complaints:

3. Other Associated illness:

Disease	Yes / No	Duration	Disease	Yes / No	Duration	Disease	Yes / No	Duration
DM			Arthritis – Osteo / Rheumatoid			Alcohol intake		
HT			Carcinoma			Similar Ailment		
IHD/CAD			Cataract / Glaucoma			Any surgery in Past		
COPD/TB/Asthma			Blood Transfusion / HIV / Related Disease			Any Other Ailment		

In maternity Claim:- Obst. History	Any abnormality noticed	No. Of Live Children:
LMP	EDD	Mode of Delivery – Normal

In Case of accident:- MLC No.	Non MLC	Influence of alcohol:	Yes/No
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Relevant Positive Clinical Findings:

Relevant Positive Investigation reports:

Date & Time of hospitalization:

Expected duration

Room No:

Indication for Admission:

Estimated Expenses

Diagnosis: Provisional / Final

Plan of Treatment: Conservative/Surgical

4. Non-Package					Package	
Room Rent & Nursing Care	Investigation	Consultation	Surgical Procedure Charges (Total)	Medicines	Package	Cost of implant

Please Note: All the above columns should be completely filled. No Slashes Allowed. Inadequate information would lead to delay in our response. Progress Reports required if stay is beyond 3 days regular. If there is any Discrepancy in Pre-authorization & Discharge Summary, our Pre-authorization would automatically stand Cancelled & we are not liable to any payment.

If cashless facility is not allowed hospital has to informed AHCI in writing AHCI would update my Sum Insured

Identity of the patient verified

Seal & Regn. No.
alongwith

Contact No's:

Name & signature of Consultant

DECLARATION

I solemnly declare that the information provided by me and my consultant is true to the best of my knowledge. In case my claim is rejected, I hereby undertake to pay the Hospital / Alankit Health Care Ltd (AHCL) the expenses, they have paid for my hospitalization. I hereby authorize the hospital to release my medical record to AHCI for the purpose of verification/authorization/settlement of my claim.

Dated:

At:

Name & signature of the patient/claimant