



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	Mobile No:
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 Coordinator			Empanelment 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 : b) Hypertension : c) Heart Disease : d) Br. Asthma : e) COPD : f) Osteo Arthritis : g) Cancer : h) Any history of Alcohol abuse / intoxication : i) Any HIV or STD / Related ailments :		
Expected no. of days stay in Hosp					
Class of accommodation					
Per Day Room Rent + Nursing & Service Charges + Patient's Diet					
Expected cost for Investigation + Medicines + Consumables & other Hospital expenses if any & OT Charges					
Doctor's = Surgeon + Asst Surgeon + Anesthetist Fees + Visit Charges					
All inclusive package charges if any applicable					
Any separate cost of Implants (if applicable please specify)					
SUM TOTAL EXPECTED COST OF HOSPITALIZATION Rs :					
* MANDATORY IN MATERNITY		* MANDATORY IN RTA		* MANDATORY FRO CALL CASES	
Menstrual History Obstetric History G _____ P _____ A _____ L _____ LMP : _____ EDD : _____ NORMAL / LSCS Expected		H/O ALCOHOL ABSUE MLC / FIR COPY CIRCUMSTANCES		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/We agree 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.