REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

DETAILS OF THE THIRD PARTY ADMINISTRATOR **(To be filled in block letters)**

a)Name of TPA : **PARAMOUNT HEALTH SERVICES & INSURANCE TPA PVT.LTD. (IRDA LICENCE No .006)**

b)**Toll free phone number** : 1800-22-66 55 c) **FAX Number** : 022- 66444754 / 66444755 / 66444709 **E-mail**- al.request@paramountpa.com

PROVIDER CODE **ROHINI CODE**

TO BE FILLED BY THE INSURED / PATIENT

a) Name of the Patient:

b) Gender: Male Female c) Age: years months d) Date Of Birth:

e) Contact number: f) MDID Number:

g) Policy number: h) Employee ID:

i) Previous Policy Details Policy No: j) Insurance Company:

k) Currently do you have any other Mediclaim/Health insurance: Yes No Give details:

l) Do you have a family physician: Yes No m) Name of the family physician:

n) Contact number,If any : (PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THIS FORM)

TO BE FILLED BY THE TREATING DOCTOR I HOSPITAL

a) Name of the treating doctor: b) Contact number:

c) Nature of ILLNESS /Disease with presenting complaints

d) Relevant clinical findings:

e) Duration of the present ailment: Days I) Date of first consultation

II) Past history of present ailment if any:

f) Provisional diagnosis:

ICD 10 Code :

g) Proposed line of treatment : Medical Management Surgical Management Intensive care Investigation Non allopathic treatment

h) If Investigation &/ or Medical Management provide details:

i) Route of drug administration: Oral Parenteral

i) If Surgical, name of surgery :

Type of Anaesthesia: Local GA Spinal I) ICD 10 PCS Code:

In case of accident I) Is it RTA: Yes No II) Date of injury III) MLC: Yes No IV) FIR No.:

V) Injury/Disease caused due to substance abuse/alcohol consumption: Yes No VI) Test conducted to establish this: Yes No (If Yes, attach reports)

VII) How did injury occur:

I) In case of Maternity: G P L A Date of Delivery

a) Date of admission: b) Time d) Expected no. of days stay in hospital: Days

c) Is this an emergency/a planned hospitalization event?: Emergency Planned e) Room Type

Details of the patient admitted

f) Per Day Room Rent + Nursing & Service Charges + Patient's Diet: Rs.

g) Expected cost for investigation + diagnostics. : Rs.

h) ICU Charges: Rs.

i) OT Charges: Rs.

j) Professional fees Surgeon + Anesthetist Fees + consultation Charges: Rs.

k) Medicines + Consumables + Cost of Implants (if applicable please specify) . Other hospital expenses if any: Rs.

l) All inclusive package charges if any applicable Rs.

m) Sum Total expected cost of hospitalization Rs.

Mandatory:Past History of any chronic illness **Yes** No If yes, since (month/year)

	Yes	No	If yes, since (month/year)
Diabetes			
Heart Disease			
Hypertension			
Hyperlipidemias			
Osteoarthritis			
Asthma /COPD / Bronchitis			
Cancer			
Any HIV or STD /Related ailments			
Alcohol or drug abuse			

Any other Ailment give details:

(PLEASE READ VERY CAREFULLY)

DECLARATION

We confirm having read understood and agreed to the Declarations on the reverse of this form

a) Name of the treating doctor:

b) Qualification: c) Registration No. with State Code:

Signature of treating doctor: E-mail Id

Name of Hospital/Nursing Home :

Hospital City : Tel/Mobile No.: Fax No.:

Hospital Seal (Must include Hospital ID): Patient / Insured Name & Signature:

DECLARATION BY THE PATIENT / REPRESENTATIVE

I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/T.P.A after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.

Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer / TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.

All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/T.P.A not governed by the terms and conditions of the policy will be paid by me. In case any clarification is needed on admissibility of a particular item I shall contact T.P.A at the Toll Free Number on the reverse of this form.

I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the Insurer / T.P.A

I agree and understand that T.P.A is in no way warranting the service of the hospital & that the Insurer / TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.

I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that, in respect of the above treatment, no benefits are admissible under any other Medical Scheme or Insurance

I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.

a) Patient's / Insured's Name:

b) Contact number:

d) Patient's / Insured's Signature:

E-mail ID of Insured:

HOSPITAL DECLARATION

1. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.

2. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent to TPA / Insurance Company within 7 days of the patient's discharge.

3. All non medical expenses , OR expenses not relevant to hospitalization or illness, OR expenses disallowed in the Authorization Letter of the TPA / Insurance Co, OR arising out of incorrect information in the pre-authorisation form will be collected from the patient.

4. WE AGREE THAT TPA / INSURANCE COMPANY WILL NOT BE LIABLE TO MAKE THE PAYMENT IN THE EVENT OF ANY DISCREPANCY BETWEEN THE FACTS IN THIS FORM AND DISCHARGE SUMMARY or other documents.

5. The patient declaration has been signed by the patient or by his representative in our presence.

6. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.

7. We will abide by the terms and conditions agreed in the MOU.

Hospital Seal

Doctor's Signature

DOCUMENTS CHECKLIST:FOR FASTER PRE-AUTHORISATION

- ☐ KYC documents of patient.
- ☐ Admission notes.
- ☐ Complete medical History.
- ☐ Supporting investigation report.
- ☐ CKYC Form for claim amount more than 100000/-

Insurer may required further documents to process the request

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

1. Detailed Discharge Summary and all Bills from the hospital

2. Cash Memos from the Hospitals / Chemists supported by proper prescription.

3. Receipts and Pathological Test Reports from Pathologists, supported by note from the attending Medical Practitioner / Surgeon recommending such pathological Tests.

4. Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.

5. Certificates from attending Medical Practitioner / Surgeon that the patient is fully cured.