



REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

Medi Assist

Name of the Hospital

Hospital Location

Hospital Fax No.

DETAILS OF THIRD PARTY ADMINISTRATOR

a) Name of TPA company: Medi Assist Insurance TPA Pvt Ltd

b) Toll Free Phone Number: 1800 425 9449

c) Toll Free FAX Number: 1800 425 9559

To Be filled in By Insured / Patient

a) Name of the Patient:

b) Gender:

c) Contact number:

g) Policy number/Name of Corporate:

h) Currently do you have any other Mediclaim/Health Insurance:

Give details:

i) Do you have a family physician:

k) Contact number, if any:

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

a) Name of the treating doctor:

c) Name of ILLNESS / Disease with presenting complaints

e) Duration of the present ailment:

f) Provisional diagnosis:

g) Proposed line of treatment:

h) If investigation / or Medical Management provide details:

i) If surgical, name of surgery:

j) If other treatments provide details:

k) In case of accident:

l) Injury/Disease caused due to substance abuse / alcohol consumption:

m) In case of Maternity:

Details of the patient admitted

a) Date of admission:

c) Is this an emergency/planned hospitalization event?

d) Expected no. of days stay in hospital:

f) Per Day Room Rent + Nursing & Service charges + Patient's Diet:

g) Expected cost for investigation + diagnostic:

h) ICU Charges:

i) OT Charges:

j) Professional fees Surgeon + Anesthetist Fees + Consultation Charges:

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

l) All inclusive package charges if any applicable:

m) Sum total expected cost of hospitalization

b) Contact Number: 089173080300

Relevant clinical findings:

ii) Past history of present ailment any:

I.C.D-10 Code:

i) Route of drug administration:

I.C.D-10PCS Code:

k) How did injury occur:

iii) Reported to Police:

vi) Test conducted to establish this:

Date of Delivery / LMP:

Mandatory:

Past history of any chronic illness if yes, since

(Month/year)

Diabetes

Heart Disease

Hypertension

Hypertension

Hypertension

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DECLARATION

PLEASE READ VERY CAREFULLY

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

a) Name of the treating doctor:

b) Qualification:

c) Registration No. with State Code:

Hospital Seal (Must include Hospital ID):

Dr. G. RAVI KUMAR, MD., DM.

Regd. No. 50031

Consultant Cardiologist

OMNI RK Super Special Hospital
(A Unit of INCOR Hospital (P) Ltd.)
Visakhapatnam-4

Patient/Insured Name & Signature:

IMPORTANT: PLEASE TURN OVER