PLEASE FAX / SCAN PAGE 1 ONLY

Medi Assist

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

Name of the Hospital

Hospital Location Hospital ID

Hospital Fax No. Hospital Phone No

DETAILS OF THIRD PARTY ADMINISTRATOR

(To be Filled in block letters)

a) Name of TPA: 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: SURNAME FIRST NAME

b) Gender: ☐ Male ☐ Female c) Age: Years YY Months MM d) Date of birth DD MM YYYY

e) Contact number: f) Insured Card ID Number:

g) Policy number/Name of corporate: h) Employee ID:

h) Currently do you have any other Mediclaim/Health Insurance: ☐ Yes ☐ No Company Name

Give details:

i) Do you have a family physician ☐ Yes ☐ No j) Name of the family physician

k) Contact number, if any:

(PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THIS FORM)

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

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

c) Name of ILLNESS / Disease with presenting complaints

d) Relevant clinical findings:

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

ii. Past history of present ailment if any:

f) Provisional diagnosis:

iii. ICD 10 Code:

g) Proposed line of treatment: ☐ Medical Management ☐ Surgical Management ☐ Intensivecare ☐ Investigation ☐ Non allopathic treatment

h) If investigation / or Medical Management provide details:

i. Route of drug administration:

i) If Surgical, name of surgery:

i. ICD 10 PCS Code:

j) If other treatments provide details:

k) How did injury occur:

l) In case of accident: I. Is it RTA: ☐ Yes ☐ No ii. Date of injury: MM YY YY iii. Reported to Police ☐ 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)

m) In case of Maternity: G P L A Date of Delivery / LMP: DD MM YY

Details of the patient admitted

a) Date of admission: DD MM YY b) Time HH MM

c) Is this an emergency/a planned hospitalization event ☐ Emergency ☐ Planned

d) Expected no. of days stay in hospital: Days e) Room Type

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 If yes, since (Month/ year)

- ☐ Diabetes MM YY
- ☐ Heart Disease MM YY
- ☐ Hypertension MM YY
- ☐ Hyperlipidemias MM YY
- ☐ Osteoarthritis MM YY
- ☐ Asthma/ COPD / Bronchitis MM YY
- ☐ Cancer MM YY
- ☐ Alcohol or drug abuse MM YY
- ☐ Any HIV or STD / Related ailments MM YY

Any other Ailment give details:

(PLEASE READ VERY CAREFULLY)

DECLARATION

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

a) Name of the treating doctor: SURNAME FIRST NAME MIDDLE NAME

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

Hospital Seal (Must include Hospital ID)

Patient/ Insured Name & Signature:

IMPORTANT: PLEASE TURN OVER

DECLARATION BY THE PATIENT / REPRESENTATIVE

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

2. 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.

3. All non-medical expenses and expenses not relevant to current hospitalization and the amount 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.

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

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

6. 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 with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.

7. 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:_____ c) Patient's / Insured's Signature:_____

d) Contact Number of Attending Relative:_____

HOSPITAL DECLARATION

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

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

2. 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 represent in our presence.

6. We agree provide clarification 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 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.

Medi Assist

CASHLESS CLAIM FORM

TO BE FILLED IN BY THE HOSPITAL

The issue of this Form is not to be taken as an admission of liability

Please include the original preauthorization request from in lieu of PART A

(To be Filled in block letters)

SECTION A

DETAILS OF HOSPITAL

a) Name of the hospital:

b) Hospital ID: c) Type of Hospital: Network : Non Network : (if non network fill section E)

d) Name of the treating doctor: SURNAME FIRST NAME MIDDLE NAME

e) Qualification: f) Registration No. with State Code: g) Phone No.

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: SURNAME FIRST NAME MIDDLE NAME

b) IP Registration Number: c) Gender: Male Female d) Age: Years Y Y Months M M e) Date of birth: D D M M Y Y

f) Date of Admission: D D M M Y Y g) Time: H H M M h) Date of Discharge: D D M M Y Y i) Time: H H M M

j) Type of Admission: Emergency Planned Day Care Maternity k) If Maternity l) Date of Delivery: D D M M Y Y ii) Gravida Status: :

l) Status at time of discharge: Discharge to home Discharge to another hospital Deceased m) Total claimed amount

SECTION C

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 PCS	Description
I. Primary Diagnosis:			I. Procedure 1:		
ii. Additional Diagnosis:			ii. Procedure 2:		
iii. Co-morbidities:			iii. Procedure 3:		
iv. Co-morbidities:			iv. Details of Procedure:		

c) Pre-authorization obtained: Yes No d) Pre-authorization Number:

e) If authorization by network hospital not obtained, give reason:

f) Hospitalization due to injury: Yes No I. If Yes, give cause Self-inflicted Road Traffic Accident Substance abuse / alcohol consumption

ii) If injury due to substance abuse / alcohol consumption, Test conducted to establish this: Yes No (If Yes, attach reports) iii. If Medico legal: Yes No iv. Reported to Police Yes No

v. FIR No. vi. If not reported to police give reason:

SECTION D

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- Claim Form duly signed
- Original Pre-authorization request
- Copy of the Pre-authorization approval letter
- Copy of Photo ID Card of patient Verified by hospital
- Hospital Discharge summary
- Operation Theatre Notes
- Hospital main bill
- Hospital break-up bill
- Investigation reports
- CT/MR/USG/HPE investigation reports
- Doctor s reference slip for investigation
- ECG
- Pharmacy bills
- MLC reports & Police FIR
- Original death summary from hospital where applicable
- Any other, please specify

SECTION E

DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

a) Address of the Hospital

City: State:

Pin Code: b) Phone No. c) Registration No. with State Code:

d) Hospital PAN: e) Number of inpatient beds f) Facilities available in the hospital i. OT Yes No ii. ICU Yes No

iii. Others:

SECTION F

DECLARATION BY THE HOSPITAL

(PLEASE READ VERY CAREFULLY)

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date: D D M M Y Y

Place:

Signature and Seal of the Hospital Authority:

GUIDANCE FOR FILLING CLAIM FORM - PART B (To be filled in by the hospital)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A - DETAILS OF HOSPITAL		
a) Name of the hospital:	Enter the name of hospital	Name of the hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by the TPA
c) Type of Hospital	Indicate whether in network or non network hospital	Tick the right option
c) Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualification of the treating doctor	Abbreviations of educational qualifications
f) Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number
SECTION B - DETAILS OF THE PATIENT ADMITTED		
a) Name of Patient	Enter the name of patient	Name of patient in full
b) IP registration Number	Enter insurance provider registration number	As allotted by the insurance provider
c) Gender	Indicate Gender of the patient	Tick Male or Female
d) Age	Enter age of the patient	Number of years and months
e) Date of Birth	Enter date of birth	Use dd-mm-yy format
f) Date of Admission	Enter date of admission	Use dd-mm-yy format
g) Time	Enter Time of admission	Use hh:mm format
h) Date of Discharge	Enter date of Discharge	Use dd-mm-yy format
i) Time	Enter time of Discharge	Use hh:mm format
j) Type of Admission	Indicate type of admission of patient	Tick the right option
k) If Maternity		
i. Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
ii. Gravida Status	Enter Gravida status if maternity	Use standard format
l) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
M) Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)
SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
a) ICD 10 Code		
Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
Additional Diagnosis	Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text
Co-morbidities	Enter the ICD 10 Code and description of the Co-morbidities	Standard Format and Open text
b) ICD 10 PCS		
Procedure 1	Enter the ICD 10 Code and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD 10 Code and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 Code and description of the third procedure	Standard Format and Open text
Details of Procedure	Enter the details of the procedure	Open text
c) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
d) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
e) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
f) Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick Yes or No
Cause	Indicate cause of injury	Tick the right option
If injury due to substance abuse/alcohol consumption test conducted to establish this	Indicate whether test conducted	Tick Yes or No
Medico Legal	Indicate whether injury is medico legal	Tick Yes or No
Reported to Police	Indicate whether police report was filed	Tick Yes or No
FIR No.	Enter first information report number	As issued by police authrities
If not reported to police, give reason	Enter reason for not reporting to police	Open text
SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST		
Indicate which supporting documents are submitted		
SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL		
a) Address	Enter the full postal address	Include Street, City and Pin Code
b) Phone No.	Enter the phone number of hospital	Include STD code with telephone number
c) Registration No. with State Code	Enter the registration number of the Hospital obtained from local body like City Corporation / Municipality	As allocated by the City Corporation / Municipality
d) Hospital PAN	Enter the permanent account number	As allocated by the Income Tax Department
e) Number of Inpatient beds	Enter the number of inpatient beds	Digits
f) Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify
SECTION F - DECLARATION BY THE HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign. and stamp		