PLEASE FAX / SCAN PAGE 1 ONLY (PART C)

REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE POLICY

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

a) Name of TPA / Insurance Company :

b) Toll Free Phone Number :

c) Toll Free FAX :

TOBE FILLED BY THE INSURED / PATIENT

a) Name of the Patient :

b) Gender : Male ☐ Female ☐ c) Age : Years Y Y Months M M

d) Date of Birth : D D M M Y Y e) Contact Number :

f) Contact number of attending relative : g) Insured card ID number :

h) Policy Number/Name of Corporate : i) Employee ID :

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

Give Details :

k) Do you have family physician : ☐ Yes ☐ No l) Name of the family physician :

m) 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) Nature of ILLNESS/ Disease with presenting complaints : d) Relevant clinical findings :

e) Duration of the present ailment : Days (i) Date of first consultation : D D M M Y Y

(ii) Past History of present ailment, if any :

f) Provisional Diagnosis : (i) 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 :

i) If Surgical, Name of Surgery : (i) ICD 10 PS 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 : D D M M Y Y

(iii) Reported to Police ☐ Yes ☐ No (iv) FIR No. :

(v) Injury/Disease caused due to substance abuse ☐ Yes ☐ No

(vi) Test Conducted to establish this ☐ Yes ☐ No (If Yes, attach reports)

m) In case of Maternity ☐ G ☐ P ☐ L ☐ A n) Date of Delivery D D M M Y Y

Details of the patient admitted		Mandatory: Past history of any chronic illness	If yes, since
a) Date of admission	D D M M Y Y	☐ Diabetes	M M : Y Y
b) Time	H H : M M	☐ Heart Disease	M M : Y Y
c) Is this an emergency/a planned hospitalisation	☐ Emergency ☐ Planned	☐ Hypertension	M M : Y Y
d) Expected no. of days stay in hospital	days	☐ Hyperlipidaemia	M M : Y Y
e) Room Type		☐ Osteoarthritis	M M : Y Y
f) Per Day Room Rent + Nursing & Service Charges + Patient's Diet	₹	☐ Asthma / COPD / Bronchitis	M M : Y Y
g) Expected cost for investigation + diagnostics	₹	☐ Cancer	M M : Y Y
h) ICU Charges	₹	☐ Alcohol or Drug Abuse	M M : Y Y
i) OT Charges	₹	☐ Any HIV or STD / Related Ailments	M M : Y Y
j) Professional Fees+ Anaesthetist Fees+ Consultation Charges	₹	Any Other Ailments, give details	
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 hospitalisation**	₹		

(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 :

(IMPORTANT – PLEASE TURN OVER)

Hospital Seal (Must include Hospital Id) :

Patient / Insured Name & Signature :

PAGE 2 : NOT TO BE FAXED / SCANNED

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 amounts over & above the limit authorized by the Insurer/TPA 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 time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the Insurer / TPA.
5. I agree and understand that TPA 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.
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, 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 : _____

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 Authorisation 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 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 I 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.