



FUTURE GENERALI

TOTAL INSURANCE SOLUTIONS

20

TOLL FREE PHONE: 1800 103 8889

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PRE-AUTHORIZATION / CLAIM FORM FOR CASHLESS FACILITY

Patient Name: _____ Health Card No. _____

Gender: Male Female Age: _____ years Employee ID / Company Name _____

Patient Mobile No. _____ Expected Admission Date: _____ Expected Length of Stay: _____ days

Name of Treating Doctor: _____ Mobile No: _____

Name of Family Physician: _____ Mobile No: _____

Name of Hospital: _____ City: _____

Details of presenting complaints: _____

Duration of Allment: _____ years _____ months _____ days Provisional Diagnosis: _____

Relevant Clinical Findings: _____

Investigations Report (if any): _____

Proposed line of treatment during hospitalization: _____

PAST HISTORY OF THE FOLLOWING WITH DURATION:

Disease / Allment	Past History	Duration/ other details
Hypertension / Cardiovascular Diseases	<input type="radio"/> Yes <input type="radio"/> No	
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	
Asthma	<input type="radio"/> Yes <input type="radio"/> No	
Any Surgery / Hospitalization	<input type="radio"/> Yes <input type="radio"/> No	
Any Other Disease / Disability	<input type="radio"/> Yes <input type="radio"/> No	
Obstetric History	<input type="radio"/> Yes <input type="radio"/> No	Status : G P A L LMP:
Intentional Self Injury	<input type="radio"/> Yes <input type="radio"/> No	
Accidental injury under the influence of Alcohol or Intoxicating Drugs	<input type="radio"/> Yes <input type="radio"/> No	

Expense Head	Amount (Rs.)	Expense Head	Amount (Rs.)
Room Rent		Investigations	
Doctor / Consultant visit charges		Medicines / Consumables	
Surgeon charges		Equipment / Monitor etc	
Operation Theatre Charges		Miscellaneous (specify)	
Package Charges		Service Tax	

Estimate of Expenses: Total Amount Rs. _____ Class of accommodation: _____

I have completed this form and will be responsible for correctness of the medical information certified by me. I agree that Future Generali shall not be liable to make payment in case of any discrepancy between the preauthorization form and discharge summary.

Signature of Doctor / Hospital Representative: _____ Stamp / Seal of Hospital _____

BENEFICIARY CONSENT / AUTHORISATION

I have 'No Objection' to Future Generali obtaining details of my treatment / collecting documents and also hereby authorize Future Generali to pay the hospital bill from the sum insured of my insurance policy. I also undertake to pay all non medical / non authorized expenses in the hospital bill directly to the hospital at the time of discharge. In case Future Generali issues "Denial of cashless facility" to the provider, I have 'No objection' in paying the hospital bill for the treatment given. All information provided above is true and I agree that if I have provided any false or untrue information, my right to claim the expenses shall be absolutely forfeited.

NAME OF INSURED _____ SIGNATURE OF INSURED: _____

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Health