PLEASE FAX / SCAN PAGE 1 ONLY

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICLAIM INSURANCE POLICY

(TO be Filled in Block letters)

DETAILS OF THE THIRD PARTY ADMINISTRATOR

a) Name of TPA / Insurance Company: Health India TPA Services Pvt Ltd.
b) Toll free phone number: 1800 2201 02
c) Fax: 022-4247 1815/957

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) 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 a 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 Present disease with presenting complaints: d) Relevant clinical findings:
e) Duration of the present ailment: Days i. Date of first consultation: k. Past history of present ailment, if any:
f) Provisional diagnosis: l. 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: j. Route of drug administration:
i) If Surgical, name of surgery: k. ICD 10 PCS Code:
j) If other treatments, provide details: l) How did the injury occur?
k) In case of accident: i. Is it RTA? Yes No ii. Date of injury: 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:

Details of the patient admitted

a) Date of admission: b) Time:
c) Is this an emergency / a planned hospitalisation event? Emergency Planned
d) Expected no. of days in hospital: Days e) Room Type:
f) Per Day Room Rent + Nursing & Service Charges + Patient's Diet:
g) Expected cost of investigation + diagnostics:
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 hospitalisation:

Mandatory ! Past History of any chronic illness

	If Yes, since (month / year)
Diabetes	
Heart Disease	
Hypertension	
Hyperlipidemia	
Osteoarthritis	
Asthma / COPD / Bronchitis	
Cancer	
Alcohol or drug abuse	
Any HIV or STD / Related ailments	

Any other Ailment, give details:

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: