MEDSAVE HEALTH CARE LIMITED

F-701A, Lado Sarai, Behind Golf Course, New Delhi - 110030

PRE-AUTHORISATION FORM FOR HOSPITALISATION

FAX US AT --- 011-29521067 / 71 Mail: cashless@medsave.in

To Be Filled By Treating Doctor	Policy No.					Date:	
Name of Patient		Age		Sex		Relation	
Name of Employee			Card No.			Employee ref. no.	
Company Name				Email:			
Communication Address:							

Details of Treating physician / surgeon and hospital

Name of treating physician / Surgeon						Reg. no.	
Qualification						Mobile	
Name of hospital							
Hospital registration no.							
Hospital. Tel. No.			Hosp. Fax no.			Email	

Details of Diagnosis

Detailed diagnosis:							
Symptoms on admission							
Date of first onset of symptoms			Date of first diagnosis				
For maternity only	LMP	EDD	Obstetrics History : G___ P___ L___ A				
For RTA Cases	FIR	MLC	Alcohol / Drug Intoxication				

Treatment Proposed (Please tick (√) where applicable)

Date of admission				Expected length of stay			Less than 24 hrs. Yes / No (√)
	Inject.(√)	Oral (√)		Inject.(√)	Oral (√)		
Antibiotics			Steroids			IV transfusions	
Anti-inflam. Drugs			Nutrients			Chaemotherapy	
Neuro-musc. Drugs			Sedatives			Radiation	
Cardiac drugs			Diuretics			Blood & comp.	
Respiratory drugs			GI drugs			Continuous traction	
Other (please specify)							
Procedures (describe)							
Surgical treatment (describe)							
Type of Anaesthesia							

Past History (Please specify duration)

	Since	(Please provide details for below if applicable)								Since	
Hypertension		History of surgery									
Cardiac Illness		History of similar complaints if any									
Diabetes		History of related ailments if any									
Respiratory Illness											
Any Other Illness											

Estimate of expenses

Room Rent ICU	Rs.	Surgeon Anaesthtist, Physician. etc	Rs.	OT Charges, OT drugs, diagnostics, Pharmacy	Rs.
				Total	

DECLARATION

- I hereby declare that the information provided in the form is true to the best of my knowledge. and authorize MHCL to seek any further information from the treating doctor / hospital if needed
- I am aware that the liability of MHCL for treatment is limited to facilitating credit and refusal of credit does not amount to rejection of claim
- I Undertake that if cashless facility is availed, all original documents, including the discharge summary and investigation reports shall be handed over to the hospital at the time of discharge along with the signed claim form and the hospital in turn will ensure that these documents are submitted at MHCL within 7days after discharge from hospital
- I am aware of my health insurance cover and if the hospital expenses exceed the amount, I shall be liable to pay the remainder of the amount at the time of discharge
- I undertake to pay all non-medical expenses incurred in the hospital at the time of discharge
- If the hospitalization comes under any of the policy exclusions & is not reimbursed by the insurance company, I undertake to pay the amount to MHCL who have kindly extended the hospital credit facility
- We have no objection to any MHCL Official to investigate the case.
- MHCL will not be liable to pay the bill on finding any discrepancy in the documentation or reports.

Date_____ Employee Signature_____

- As treating physician, I hereby declare that the medical information declared in the form is accurate to the best of my knowledge.

Date_____ Hospital Stamp Treating Physician Signature_____