PLEASE FAX / SCAN PAGE 1 ONLY

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 / Insurance company: **TTK HEALTHCARE TPA PRIVATE LIMITED**

b) Toll Free Phone Number:

c) Toll Free Fax:

TO BE FILLED BY THE INSURED / PATIENT

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

b) Gender: ☐ Male ☐ Female c) Age: . Years [Y][Y] Months [M][M] d) Date of birth [D][D] [M][M] [Y][Y][Y][Y]

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 f) Date of first consultation [D][D] [M][M] [Y][Y]

ii. Past history of present ailment if any:

f) Provisional diagnosis:

iii. 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 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: [M][M] [Y][Y] [Y][Y] 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: [D][D] [M][M] [Y][Y]

Details of the patient admitted

a) Date of admission: [D][D] [M][M] [Y][Y] b) Time [H][H] [M][M]

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	[M][M]	[Y][Y]
☐ Heart Disease	[M][M]	[Y][Y]
☐ Hypertension	[M][M]	[Y][Y]
☐ Hyperlipidemias	[M][M]	[Y][Y]
☐ Osteoarthritis	[M][M]	[Y][Y]
☐ Asthma / COPD / Bronchitis	[M][M]	[Y][Y]
☐ Cancer	[M][M]	[Y][Y]
☐ Alcohol or drug abuse	[M][M]	[Y][Y]
☐ Any HIV or STD / Related ailments	[M][M]	[Y][Y]

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)