Authorization Form

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PLEASE FAX/SCAN PAGE 1 ONLY

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

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

a. Name of the TPA/Insurance Company :

b. Toll free phone no : c. Toll free FAX :

TO BE FILLED BY INSURED/PATIENT

a. Name of the patient :

b. Gender : Male ☐ / Female ☐ c) Age (YY/MM) : d) Date of birth (DD/MM/YYYY) :

e. Contact Number : f) Insured Member ID card no :

g. Policy No./Corporate Name : h. Employee ID :

i. Currently do you have any Mediclaim/Health Insurance : Yes ☐ / No ☐ j. Company Name :

Give details :

k. Do you have a family physician : Yes ☐ / No ☐ l. Name of the family physician :

m. Contact No, if any :

PL COMPLETE DECLARATION ON THE REVERSE SIDE OF THE FORM

TO BE FILLED BY TREATING DOCTOR /HOSPITAL

a. Name of treating doctor : b. Contact No :

c. Nature of illness/ Disease with presenting complaints : d. Relevant clinical findings :

e. Duration of present ailment : Days f. Date of first consultation :

g. Past history of present ailment, if any : h. Provisional Diagnosis :

i. ICD Code :

j. Proposed line of treatment : Medical Management ☐ Surgical management ☐ Intensive Care Unit ☐ Investigation ☐ Non allopathic treatment ☐

k. Investigational &/or Medical Management provide details : l. Route of drug administration :

m. If surgical name of surgery : n. ICD 10 PCS code :

o. If other treatment provide details : p. How did injury occur :

q. In case of Accident : i) Is RTA : Yes ☐ / No ☐ ii) Date of injury : iii) Reported to policy : 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 report

r. In case of maternity : Gravida ☐ Para ☐ Living Children ☐ Abortions ☐ Date of delivery :

Details of patient admitted

a. Date of admission : b. Time :

c. Is this a emergency/a planned hospitalisation 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)
i. Diabetes	
ii. Heart Disease	
iii. Hypertension	
iv. Hyperlipidemia	
v. Osteoarthritis	
vi. Asthma/ COPD/Bronchitis:	
vii. Cancer	
vii. Alcohol or drug abuse	
vii. Any HIV or STD / Related ailments	

Any other Ailment give details: