BAJAJ | Allianz
Bajaj Allianz General Insurance Company Limited.
Regd. & Head Office : GE Plaza, Airport Road, Yerawada, Pune 411 006
Health Administration Team : *A - Wing 2nd Floor, Bajaj Finserv Building, Behind Weikfield IT Park, Off Nagar Road, Viman Nagar | Pune - 411 014
Phone No.: 020-30305858/ 1800-103-2529 Fax: 020-30512224/ 6/ 7
Email: preauth@bajajallianz.co.in

(To be filled in block letters)

CASHLESS FORM

PLEASE FAX/SCAN PAGE 1 AND 2 ONLY

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

DETAILS OF THE PROVIDER

Hospital Name/nursing Home Name: _____

City Name: _____ Pin Code: | | | | | | | | | | | | |

State Name: _____ Hosp Id: | | | | | | | | | | | | |

Landmark: _____

Hospital Contact No: _____ Fax No: _____ TPA desk No _____ Email id: _____

SECTION A

TO BE FILLED BY THE INSURED/PATIENT

a) Name of the Patient: _____

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) Name of the Attendant: _____ f) Contact number, if any: | | | | | | | | | | |

g) Contact number: | | | | | | | | | | h) Insured card ID number: | | | | | | | | | | | | | | | |

I) Policy number I Name of corporate: _____

j) Employee ID: | | | | | | | | | | | | | | | |

k) Currently do you have any other Mediclaim / Health insurance: ☐ Yes ☐ No

Company Name: _____

Give details: _____

l) Do you have a family physician: ☐ Yes ☐ No m) Name of the family physician: _____

n)Contact number, if any: | | | | | | | | | |

o) Insured E-mail id _____ **(PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THIS FORM)**

SECTION B

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

a) Name of the treating doctor: _____ b) Contact number: | | | | | | | | | | |

c) Nature of ILLNESS / Disease with presenting complaints _____

d) Relevant clinical findings: _____

e) Duration of the present ailment: | | | | Days i. Date of first consultation: | D | D | | M | M | | Y | Y | Y | Y |

i. Past history of present ailment if any: _____

f) Provisional diagnosis _____ i. ICD 10 Code: | | | | | | | | | | |

g) Proposed line of treatment: ☐ Medical Management ☐ Surgical Management ☐ Intensive care ☐ Investigation ☐ Non allopathic treatment

h) If Investigation & I 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: | D | D | | 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)

l) In case of Maternity: G ☐ P ☐ L ☐ A ☐ Date of Delivery: | D | D | | M | M | | Y | Y | Y | Y | LMP: | D | D | | M | M | | Y | Y | Y | Y |

SECTION C