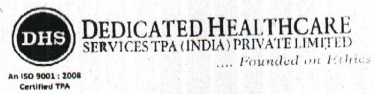
(20)



PLEASE FAX/SCAN PAGE 1 & 2 ONLY

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

(To be filled in block letters)

DETAILS OF THE THIRD PARTY ADMINISTRATOR/INSURER

Name of the Insurance Company

Name of TPA: DEDICATED HEALTHCARE SERVICES TPA (INDIA) PVT. LTD.

Toll free phone number: 1 8 0 0 2 0 9 0 2 0 1

Toll free FAX: 0 2 2 - 6 7 3 5 4 3 0 0

TO BE FILLED BY THE INSURED / PATIENT

a) Name of the Patient

b) Gender ☐ Male ☐ Female c) Age: Year Month d) Date of birth D D M M Y Y Y Y

e) Mobile Number f) Contact number of attending relative: (Mandatory)

g) Email ID h) Membership Card Number/ ID Number

In case group health insurance taken by Employer

i) Name of Employer

j) Employee ID

k) Work address

l) Currently do you have any other Mediclaim/Health insurance: ☐ Yes ☐ No If yes, please give policy details

m) Do you have a family physician ☐ Yes ☐ No n) Name of the family physician

o) Contact number

(PLEASE COMPLETE DECLARATION ANNEXED WITH THIS FORM)

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 Months Years

f) Date of first consultation

g) Past history of present ailment if any

h) Provisional diagnosis

ICD 10 Code

i) Proposed line of treatment ☐ Medical Management ☐ Surgical Management ☐ Intensive care ☐ Investigation ☐ Non-allopathic Treatment

j) If Investigation & or Medical Management provide details