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Genins India TPA Ltd
Third party administrator in Health Insurance

B-127, Sector-2, Noida-201301 (INDIA)
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Pre Authorization/ Pre – Hospitalization Form

Please read this carefully it is very important that this form be filled in carefully, completed and correctly to facilitate the processing of medical claim without causing and delay or rejection. It also helps to offer better guidance and assistance at all stages of hospitalization & reimbursement.

Part A – **To be Filled by the Hospital/ Nursing Home/ Service Provider:** (Please write full name and address)

Hospital Name: ____________________

Complete Address ____________________ City ____________

Name of the patient ____________________ Reg. No. ____________ Tel No. ____________

ID No. (As mention on the ID card): ____________________ Age ____________ Years ____________ Sex: M / F

Name of the Policy Holder ____________________ Policy No. ____________

Contact No. of Insured / Patient – Landline: ____________________ Employee Code (In case of Corporate) ____________

Proposed date of Admission ____________________ Mobile: ____________

Approx. Duration of stay ____________________ Total estimated expenses ____________

Class of accommodation ____________________ Room Charges ____________

Operation Theater Charges ____________________ Investigation Charges ____________

Name of the Treating Doctor ____________________ Doctor(s) / Surgeon(s) Fee ____________

Contact No. ____________________ Medicine & Drugs Charges ____________

Signature of the Doctor ____________________ Others ____________

Rubber Stamp ____________

The cashless facility may not be granted, if this form is not filled completely.

The change in the admissibility of the claim due to discrepancies in the information provided by the hospital in the preauthorization form and discharge summary/ hospital records would be the liability of the hospital.

Part B – **To be filled by the treating Doctor/ Consultant:**

Advised admission/ admitted under Dr. ____________________

Date of first consultation: ____________________ Reg. No. ____________ Qualification: ____________

Presenting Complaints with exact duration: ____________________ Name of the Doctor 1st Consulted ____________

History of Presenting Complaints: ____________________

Relevant Clinical Findings: ____________________

Relevant Past History ____________________ Investigation Reports (If any) ____________

Diagnosis: ____________________

Proposed line of treatment: ____________________

Details of past treatment: ____________________

Part C – **History of the following**

Hypertension ____________ Yes / No, If Yes, Since When ____________

CAD / IHD ____________ Yes / No, If Yes, Since When ____________ Diabetes Mellitus Yes / No, If Yes, Since When ____________

COPD / TB / Similar Ailment ____________ Yes / No, Since When ____________ Bronchial Asthma / Koch's and any other ____________

Any surgeries in the past ____________________ Any other Ailment ____________

Influence of alcohol / any other drugs ____________ In case of road traffic accident, please mention if the patient was under the (Please FAX the MLC copy) ____________________ yes / No (Please enclosed the FIR copy)

In maternity: Gravida status ____________ LMP ____________ EDD ____________ Para ____________ NO. of living children ____________

Please do information the covered person the in case the cashless facility is not allowed, it is not the denial of treatment or claim. The claim can be submitted for re-imbursement, for settlement on its merits.

Part D – **Declaration**

I solemnly declare that the information provided by me is true and correct to the best of my knowledge. In case my claim is rejected; I hereby undertake to pay to ____________________, the expenses, which are incurred / paid for my hospitalization. I hereby authorized the hospital to release / give photocopies of my medical record to Genins India TPA Ltd. for the purpose of verification / authorization / settlement of my claim. I also confirm that I have read and understood the terms and conditions as mentioned and are applicable.

Previous Policy Details: Policy No ____________________ Insurance Co. ____________

Previous claim details ailment ____________________ Date ____________ Amount ____________

Concurrent Policy details ____________________ Name of the Patient / Relative ____________ Relationship ____________

Signature of Patient / Relative ____________________