(20)

HDFC ERGO General Insurance Company Limited

PRE-AUTHORISATION REQUEST FORM

Name of Proposer/Employee _____ CARD No.*: _____ Policy No*. _____

Name of Patient _____

Product Name _____ Relation _____ Age/DOB D D M M Y Y Y Y

Group/Company Name of the employee _____

Employee Code _____ Mobile _____ Tel No. _____

Communication Address _____ Email ID _____

Hospital Details

Name of Hospital* _____ Hosp. code _____ Location _____

Hospital Registration No. _____ Address _____

Hosp.Tel. No. Hosp. Fax No. Hosp. Email ID

Treating Doctor Details

Name of Treating Doctor: _____ Reg. No. _____

Qualification: _____ Mobile: _____ Clinic Tel. _____

Details of Diagnosis

Symptoms on Admission _____ Date of first Onset of symptoms D D M M Y Y Y Y

Ailment* _____ Date of First Diagnosis D D M M Y Y Y Y Type Of Admission* ☐ Emergency ☐ Planned

Differential Diagnosis* _____ Investigation Findings _____

Date of Admission D D M M Y Y Y Y Expected Date of Discharge D D M M Y Y Y Y

Past History (Please Specify Duration)

	Since	Remarks		Since	Remarks
Hypertension			H/O surgery		
Dyslipidaemia			H/O Similar/Related Complaints		
Diabetes			H/O of any Cardiac Ailment		
If others specify			H/O: Alcohol/Drug abuse		

Proposed Line of Treatment

Antibiotics	☐ Inject	☐ Oral	IV Transfusions	☐ Inject	☐ Oral
Neuro-musc. Drugs	☐ Inject	☐ Oral	Chemotherapy	☐ Inject	☐ Oral
Cardiac Drugs	☐ Inject	☐ Oral	Continuous Traction	☐ Inject	☐ Oral
Respiratory Drugs	☐ Inject	☐ Oral	Radiation	☐ Inject	☐ Oral

Other* (please specify) : _____

Surgical Details

Date of surgery D D M M Y Y Y Y Type of Anesthesia ☐ LA ☐ GA ☐ Epidural ☐ Spinal ☐ Regional Block Other* : [ ]

Procedure Name _____

Maternity Details

Last Menstrual Period D D M M Y Y Y Y Expected Date of Delivery D D M M Y Y Y Y

Mode of Delivery : Normal/LSCS/Abortion/Others _____ Indication for LSCS _____

Obstetric History* Gravida _____ Para _____ Abortion _____ Live _____

RTA Details

H/O Alcohol during accident ☐ Yes ☐ No MLC/FIR done for RTA ☐ Yes ☐ No MLC/FIR No _____

Estimate of Expenses (Please Select From Below) (Accommodation Type -Room / ICU)

Room Category* ☐ General Ward ☐ Twin Sharing ☐ Single Non AC ☐ Single AC ☐ Deluxe/Suite ☐ Others

ICU Category ☐ ICU ☐ NICU ☐ MICU ☐ SICU ☐ PICU ☐ NICU

Length of Stay ☐		No of Visits ☐		Room No ☐		Bed No ☐
Room Rent / Day	Rs.	Pharmacy	Rs.	Surgeon charge	Rs.	
Investigations	Rs.	Physician Charge	Rs.	Asst. Surgeon charge	Rs.	
Package	Rs.	Nursing	Rs.	Anesthetist	Rs.	
Other	Rs.	OT charges	Rs.	Consumables	Rs.	
TOTAL*						

Total in words _____

*For RTA cases - **MLC/FIR is mandatory** *For CATARACT cases - **Type & cost of LENS is mandatory** * Any Implant/Stent/Sticker **Invoice Mandatory**

DECLARATION

I hereby declare that the information provided in the form is true to the best of my knowledge, and authorize HDFC ERGO to seek any further information from the treating doctor / hospital if needed. I undertake that if cashless facility is availed, all original documents, including the discharge summary and investigation reports shall be handed over to the hospital at the time of discharge along with the signed claim form. I am aware that without these documents the claim cannot be processed and I am liable for the same. I undertake to pay all non-medical expenses incurred in the hospital at the time of discharge. If the hospitalization comes under any of the policy exclusions & should this authorization become null and void due to wrong and/or misleading and/or incorrect information & is not reimbursed by the insurance company, I undertake to pay the amount to HDFC ERGO who have kindly extended credit facility to the hospital

Date D D M M Y Y Y Y

Signature & Stamp of Treating Dr./ Hospital _____ **Patient/Relative's Sign** _____