ICICI Lombard GENERAL INSURANCE

ICICI Lombard Health Care

CASHLESS AUTHORIZATION REQUEST NOTE

Toll Free Number: 1800 2666 • Fax Number: 1800 209 8880 / 040 6698 9160 / 61 • Email us: cashlessrequest@icicilombard.com

TO BE FILLED BY THE INSURED / PATIENT

1) Name of Patient:

2) Gender: Male Female 3) Age: Years 4) Date of Birth: 5) Mobile No.:

5) Insured Card ID No: 6)Email ID:

7) Policy No.

8) a) Corporate Policy No.: b) Corporate Policy Name:

c) Employee ID: 9) Currently do you have any other Mediclaim / Health insurance Yes No If Yes, Company Name

Give details

10) a) Name of the family physician: b) Contact Number:

11) ID/Age Proof Attached: Aadhar Card Passport Driving License 10 th Class Certificate Others

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

1) a) Name of the treating doctor b) Mobile No.:

2) a) Name of Hospital: b) Contact No.:

c) NT Code: d) Email ID: e) Fax No.

3) Nature of Illness / Disease with presenting complaints:

4) Relevant clinical findings:

5) a) Past history of present ailment, if any:

b) Duration of present ailment: Days c) Date of first consultation:

6) a) Provisional diagnosis:

b) ICD 10 Code:

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

8) a) If Investigation & / or Medical management, provide details:

b) Route of drug administration:

9) a) If Surgical, name of surgery:

b) ICD 10 PCS Code:

10) If other treatments provide details:

11) In case of accident: a) Is it RTA: b) Date of injury: c) Reported to Police: FIR No.

12) a) Injury / Disease caused due to substance abuse / alcohol consumption: b) Test conducted to establish this : , attach report.

13) a) In case of Maternity: G P L A b) Date of Delivery:

Details of the patient admitted

a) Date of admission: D D M M Y Y b) Time H H : M M

c) Is this an emergency / planned hospitalization 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: ₹

g) Expected cost for investigation + diagnostics: ₹

h) ICU Charges: ₹

i) OT Charges: ₹

j) Professional fees Surgeon + Anesthetist Fees + consultation Charge: ₹

k) Medicines + Consumables + Cost of Implants (if applicable Please specify). Other hospital expenses if any: ₹

l) All inclusive package charges if any applicable: ₹

Sum total expected cost of hospitalization: ₹

Mandatory: Past History of any chronic illness — **If yes, since (Month/year)**

Diabetes	M M Y Y
Heart Disease	M M Y Y
Hypertension	M M Y Y
Hyperlipidemias	M M Y Y
Osteoarthritis	M M Y Y
Asthma / COPD / Bronchitis	M M Y Y
Cancer	M M Y Y
Alcohol or drug abuse	M M Y Y
Any HIV or STD / Related ailments	M M Y Y
Other ailments:	

PLEASE READ VERY CAREFULLY • THIS FORM IS TO BE FILLD IN BLOCK LETTERS

DECLARATION

We confirm having read understood and agreed to the Declarations on the reverse of this form

a) Name of the treating doctor: S U R N A M E F I R S T N A M E M I D D L E N A M E

b) Qualification: c) Registration No. with state code:

Signature of treating doctor

Hospital Seal (Must include Hospital NT ID)

Patient / Insured Name & Signature:

(PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THIS FORM)