FORM 1: CASHLESS REQUEST FORM

IFFCO TOKIO GENERAL INSURANCE COMPANY LIMITED

IFFCO-TOKIO GENERAL INSURANCE Muskurate Raho

TO BE FILLED BY THE INSURED / PATIENT

Name of Patient :		Age :	Sex : M F
Contact Number :		Email :	
Name of Proposer:		Relation to Proposer:	
Address :			
Policy Type : Indv / Group (GROUP NAME)			
Card ID No.		Policy No.________	Emp.ID______
Any Past Policy (Y/N)	If Y, attach copies		
Are you presently covered under any other similar type & scheme, cancer / medical / health insurance etc. Give Details			

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

Doctor (Name & Mobile No)	Qualification:	Reg.No. :
Presenting complaints with duration:		
Relevant Clinical Findings :		
Earlier history of the present ailment if any :		
Date of First Consultation (Fax Prescription)		
Rx / Tests done so far (FAX documents) :		
Provisional Diagnosis :		ICD - 10 CM Code:

Proposed Line of Treatment : ◻ Investigation ◻ Intensive Care ◻ Medical Management ◻ Surgical

(a) If 'Investigation &/or Medical management' provide detailed line of treatment with route of drug administration :-

(b) If Surgical, name of the Surgery & its details

(c) For other treatments, furnish details : ICD 10 PCS Code :

Likely DOA	Likely length of stay	Room Type	Room No. :

In Case of ACCIDENTS : Is it RTA ◻ Y ◻ N MLC ◻ Y ◻ N Date of Injury :

How did injury occur

FIR Attached : ◻ Y ◻ N Alcohol / Drug Intoxication ◻ Y ◻ N If 'Y' send the Analyser Report

In case of MATERNITY G___P___L___A____

LMP________

HOSPITAL DETAILS

Hospital name :	Hosp ID*:	E-Mail :
Hospital Address:		Pin Code :
Key Contact Person:		Mobile

ESTIMATED EXPENSES DETAILS		Past History of chronic illness (Y/N)		If Y, Duration
Per Day Room Rent+Nursing		(a) Diabetes	: Y / N	
Consultation Charges		(b) Hypertension	: Y / N	
Investigation + diagnostics		(c) Heart Disease	: Y / N	
Medicines + Consumables		(d) Br. Asthma/COPD	: Y / N	
Surgeon fees		(e) Osteo Arthritis	: Y / N	
OT expenses		(f) Cancer	: Y / N	
Implants (if any)		(g) Any Other Ailment	: Y / N	
Any Others (pl. specify)		(h) Any h/o Alcohol	: Y / N	
All incl. Package (if applicable)		(i) Any HIV or STD	: Y / N	
TOTAL		(j) Any Other Ailment	: Y / N	

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