A Max India Joint Venture

Max Bupa Health Insurance

Pre-Authorization Form (Cashless)

HOSPITAL ID 21966

MEMBERSHIP NUMBER

DETAILS OF THE THIRD PARTY ADMINISTRATOR (To be filled in block letters)

a) Name of TPA/Insurance company:

b) Toll free phone number: c) Toll free fax:

TO BE FILLED BY THE INSURED / PATIENT

a) Name of the Patient

b) Gender ☐ Male ☐ Female c) Age Years [Y Y] Months [M M] d) Date of birth [D D M M Y Y]

e) Contact no. f) Insured card ID no.

g) Contact number of attending relative: h) Employee ID

i) Policy no. / Name of corporate

j) Currently do you have any other Mediclaim / Health insurance ☐ Yes ☐ No Company name

Give details

k) Do you have family physician ☐ Yes ☐ No l) Name of the family physician

m) Contact number if any

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

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

a) Name of the Treating Doctor b) Contact no.

c) Name of illness / disease with presenting complaints d) Relevant clinical findings

e) Duration of the present ailment Days 1) Date of first consultation [D D M M Y Y] 2) Past history of present ailment if any

f) Provisional diagnosis 1) ICD 10 code

g) Proposed line of treatment ☐ Medical management ☐ Surgical management ☐ Intensive care ☐ Investigation ☐ Non allopathic treatment

h) If investigation & / or Medical Management provide details 1) Route of drug administration

i) If Surgical, name of surgery 1) ICD 10 PCS Code

j) If other treatments provide details k) How did injury occur

l) In case of accident 1) Is it RTA ☐ Yes ☐ No 2) Date of injury [D D M M Y Y] 3) Reported to police ☐ Yes ☐ No 4) FIR no.

5) Injury / Disease caused due to substance abuse / alcohol consumption ☐ Yes ☐ No 6) Test conducted to establish this (if yes attach reports)

l) In case of Maternity ☐ G ☐ P ☐ L ☐ A Date of delivery [D D M M Y Y]

Details of patient admitted

a) Date of admission [D D M M Y Y] b) Time [H H] [M M]

c) Is this an emergency / a planned hospitalization event? ☐ Emergency ☐ Planned

d) Expected no. of days in hospital Days e) Room type

f) Per Day Room Rent + Nursing & Service Charges + Patient's diet Rs.

g) Expected cost of investigation + diagnostics Rs.

h) ICU charges Rs.

i) OT charges Rs.

j) Professional fees surgeon + Anesthetist Fees + consultation charges Rs.

k) Medicines + Consumables + Cost of Implants (if applicable please specify). Other hospital expenses if any. Rs.

l) All inclusive package charges if any applicable Rs.

m) Sum total expected cost of hospitalisation **Rs.**

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]

Any other Ailment give details

(Please read very carefully)

DECLARATION

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

a) Name of 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

Hospital Seal (Must included Hospital ID)I

Patient / Insured Name & Signature

Email us: pre.auth@maxbupa.com Fax No: 1800 3070 3333

(Important Please Turn Over for documents checklist)