60

Medi Assist

PLEASE FAX / SCAN PAGE 1 ONLY

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

Name of the Hospital

Hospital Location

Hospital Fax No. Hospital ID

Hospital Phone No

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

a) Name of TPA / Insurance company: Medi Assist India TPA Pvt Ltd b) Toll Free Phone Number: 1800 425 9449 c) Toll Free FAX Number: 1800 425 9559

To Be filled in By Insured / Patient

a) Name of the Patient: SURNAME FIRST NAME

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

e) Contact number: f) Insured Card ID Number:

g) Policy number/Name of corporate: h) Employee ID:

h) Currently do you have any other Mediclaim/Health insurance: Yes No Company Name

Give details:

i) Do you have a family physician Yes No j) Name of the family physician

k) 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 Number:

c) Name of ILLNESS / Disease with presenting complaints d) Relevant clinical findings:

e) Duration of the present ailment: Days i) Date of first consultation D D M M Y Y ii. Past history of present ailment if any:

f) Provisional diagnosis:

iii. 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: i. Route of drug administration:

i) If Surgical, name of surgery:

i. ICD 10 PCS Code:

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

l) In case of accident: i. Is it RTA: Yes No ii. Date of injury: M M Y Y Y Y iii. Reported to Police Yes No iv. FIR No.

v. Injury/ Disease caused due to substance abuse / alcohol consumption: Yes No vi. Test conducted to establish this: Yes No (If Yes attach reports)

m) In case of Maternity: G P L A Date of Delivery / LMP: D D M M Y Y

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/a 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: Rs.

g) Expected cost for 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 hospitalization 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 Declaration on the reverse of this form

a) Name of the treating doctor: SURNAME FIRST NAME MIDDLE NAME

b) Qualification: c) Registration No. with State Code:

Hospital Seal (Must include Hospital ID)

Patient/ Insured Name & Signature:

IMPORTANT: PLEASE TURN OVER