PLEASE FAX / SCAN PAGE 1 ONLY

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

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

a) Name of TPA / Insurance company: MEDICARE TPA SERVICES (I) PVT LTD

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 Months d) Date of birth: D D M M Y Y Y Y

e) Contact number: f) Contact number of attending relative: g) Insured card ID number:

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

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

Give details

k) Do you have a 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 number:

c) Nature 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: i. 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:

j) If Surgical, name of surgery: i. ICD 10 PCS Code:

l) 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: D D M M 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: 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