RELIANCE General Insurance

RCare Health — Reliance General Insurance

Helpline 1800 103 1999 (toll free) / 022 3989 8282 (charges apply)
Fax 1800 3010 3001 (toll free) / 022 3919 7849 (charges apply)
www.reliancegeneral.co.in

PRE-AUTHORIZATION REQUEST FORM

Part 1 Insured Details

Insured Name: _____ Claim No _____
Mobile No.: _____ Policy No.: _____
E-mail Id _____
If Group Policy, Company Name: _____ Employee id _____

Part 2 Patient Details

Patient Name: _____
Patient UHID _____ Age: ____ yrs DOB: d d / m m / y y Gender: ☐ Male ☐ Female
Patient Mobile No.: _____ Patient Email Id _____
Relation with insured: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Son ☐ Daughter ☐ Others _____
Address: _____
City: _____ Pin Code _____
Attendant Name: _____
Attendant Mobile no.: _____ Attendant email id _____

Part 3 Service Provide Details

Hospital Name: _____ Hospital Code: _____
Hospital Address: _____
City: _____ Pin Code _____

Contact Details (Hospital Employee)	Treating Doctor's Details
Name:	Name: Dr.
Telephone no./Mobile no.	Qualification:
Fax No.:	Registration No.:
E-mail Id	Mobile No.:

Part 4 Case Information (filled by treating doctor)

Presenting Complaint _____
Duration _____ Date of first onset/Consult _____
H/O of past illness related to present complaint _____
Relevant Clinical findings _____
Investigation findings _____

Provisional Diagnosis _____

Treatment Plan : ☐ Medical ☐ Surgical

In case of Maternity
Obstetric History G___ P___ L___ A___
LMP_____ EDD._____

In case to Injury/RTA/Self Injury
Under influence of Alcohol/Drug abuse ☐ Yes ☐ No
Attached Copy of ☐ MLC ☐ FIR ☐ PI
MLC/FIR Number: _____ Place: _____

Past Medical History		Duration/Details
HTN	☐ Y ☐ N	
IHD/CAD	☐ Y ☐ N	
Diabetes	☐ Y ☐ N	
Asthma/COPD/TB	☐ Y ☐ N	
Paralysis/CVA/Epilepsy	☐ Y ☐ N	
Arthritis	☐ Y ☐ N	
Cancer/Tumor/Cyst	☐ Y ☐ N	
STD/HIV	☐ Y ☐ N	
Alcohol/Drug abuse	☐ Y ☐ N	
Psychiatric condition	☐ Y ☐ N	
Others	☐ Y ☐ N	

Part 5 Billing details (filled by hospital)

Room Type: ☐ Single AC ☐ Single NON AC ☐ Twin Sharing AC ☐ Twin Sharing NON AC ☐ Multi-bed ☐ Others
Hospital Room Name.: _____
Type of Admission: ☐ Planned ☐ Emergency
Expected DOA: d d / m m / y y Length of Stay: _____ Days
Package Rate: ☐ Yes ☐ No
If Yes, Package Charges _____
Implant Charges _____
Remarks (If Any) _____

If Package not applicable,

Room Rent + Nursing Charges	
Surgeon/Assistant Surgeon Charges	
Anesthesia/Anesthetist Charges	
Operation theatre Charges	
Doctor's Visit Charges	
Investigation Charges	
Pharmacy Charges	
Implant Cost(If any)	
Total Cost of Hospitalization	

Consent by the Patient/Insured/Beneficiary: I/We understand that Cashless facility is not automatically guaranteed by RGICL. I/We have no objection to RGICL RCare Health Officials visiting the Hospital/Nursing Home to check the details of treatment and are authorized to collect documents pertaining to my treatment from the Hospital/Nursing Home. I/We have provided the necessary information accurately to the best of my /our knowledge. I/We agree to pay the cost of the hospitalization, if authorization given by RGICL RCare Health becomes null and void, due to wrong and incorrect information.

Patient Signature: _____ Treating Doctor's Signature: _____