REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

FAMILY HEALTH PLAN (TPA) LTD (To be filled in block letters)

A) Name of Insurance Company:

B) Toll free phone number: 1800 266 4545

TO BE FILLED BY INSURED / PATIENT

A) Name of the Patient :_____

B) Gender : Male : ____ Female ____ C) Age : Years :____ Month :____ D) Date of birth :___ ___ _____

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: ____ _____

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: _____

_____

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: _____ iii) Reported to Police: Yes____ No____

iv) FIR No: _____ v) In case of Maternity: G ____ P____ L ____ A ____ Date of Delivery: ____ _____

Details of the patient admitted		Mandatory: Past History of any chronic illness	if yes, since (month / year)
A) Date of admission: ____ _____ B) Time: _____		Diabetes _____	____ _____
C) Is this an emergency / a planned hospitalization event? : Emergency / Planned		Heart Disease	____ _____
D) Expected no. of days stay in hospital: Days_____ E) Room Type_____		Hypertension	____ _____
F) Per Day Room Rent + Nursing & Service Charges + Patient's Diet: Rs: _____		Hyperlipidemias	____ _____
G) Expected cost for investigation + diagnostics. :	Rs: _____	Osteoarthritis	____ _____
H) ICU Charges:	Rs: _____	Asthma / COPD / Bronchitis	____ _____
I) OT Charges:	Rs: _____	Cancer	____ _____
J) Professional fees Surgeon + Anesthetist Fees + consultation Charges: Rs: _____		Alcohol or drug abuse	____ _____
K) Medicines + Consumables + Cost of Implants Other Hospital expenses if any:	Rs: _____	Any HIV or STD / Related aliments	____ _____
L) All-inclusive package charges if any applicable	Rs: _____	Any other Ailment give details: _____	
M) Sum Total expected cost of hospitalization	Rs: _____	_____	
		_____	

(PLEASE READ VERY CAREFULLY)

DECLARATION

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

A) Name of the treating doctor: _____

B) Qualification: _____ C) Registration No. with State Code: _____

Hospital Seal (Must include Hospital ID): _____ Patient / Insured Name & Signature: _____

PAGE 2: NOT TO BE FAXED/SCANNED

DECLARATION BY THE PATIENT / REPRESENTATIVE

1. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/T.P.A after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.
2. Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer / TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.
3. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/T.P.A not governed by the terms and conditions of the policy will be paid by me.
4. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the Insurer / T.P.A
5. I agree and understand that T.P.A is in no way warranting the service of the hospital & that the Insurer / TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.
6. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.
7. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.

A) Patient's / Insured's Name: _____

B) Contact number: _____

C) Patient's / Insured's Signature: _____

HOSPITAL DECLARATION

1. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.
2. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent to TPA / Insurance Company within 7 days of the patient's discharge.
3. All non-medical expenses, OR expenses not relevant to hospitalization or illness, OR expenses disallowed in the Authorization Letter of the TPA / Insurance Co, OR arising out of incorrect information in the pre-authorization form will be collected from the patient.
4. WE AGREE THAT TPA / INSURANCE COMPANY WILL NOT BE LIABLE TO MAKE THE PAYMENT IN THE EVENT OF ANY DISCREPANCY BETWEEN THE FACTS IN THIS FORM AND DISCHARGE SUMMARY or other documents.
5. The patient declaration has been signed by the patient or by his representative in our presence.
6. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
7. We will abide by the terms and conditions agreed in the MOU.

Hospital Seal: _____ Doctor's Signature: _____

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

1. Detailed Discharge Summary and all Bills from the hospital
2. Cash Memos from the Hospitals / Chemists supported by proper prescription.
3. Receipts and Pathological Test Reports from Pathologists, supported by note from the attending Medical Practitioner / Surgeon recommending such pathological Tests.
4. Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.
5. Certificates from attending Medical Practitioner / Surgeon that the patient is fully cured.