anyuta SIMPLIFYING HEALTHCARE

TPA in Healthcare
(IRDA License No. 17, Dated 16/05/2002)

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

NAME OF TPA	Anyuta Medinet TPA in Healthcare Private Limited	Hospital ID, Name and Address (Stamp)
NAME OF INSURANCE CO.	State Insurance & Provident Fund Dept (GIF)	
TOLL FREE PHONE:		H. Bank account No with IFSC Code for Claim settlement by RTGS
TOLL FREE FAX:		

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY
To be filled in **block letters** in black ink only / Please fill all the Columns Completely

To Be Filled By the Insured / Patient

(1) Name of Patient:	(2) Age (Yrs) _____ (2.a) Sex: M / F
(3) Contact Number	
(4) Insured Card ID No:	(5) Policy No /Corporate _____(6) Emp ID _____
(5) Are you presently covered under any other similar type & scheme Cancer / medical / health insurance etc. (Give Details)	
(6) Name of the Family physician and Mobile no:	

To Be Filled By the Treating Doctor / Hospital

(7) Name of treating doctor & Mobile No.		
(8) Nature of ILLNESS/Disease with presenting complaints		(10) Duration of the present aliment
(9) Relevant clinical findings:		(11) Date of first consultation and earlier history of the present ailment if any
(12) a. Provisional Diagnosis	(12) b. ICD 10 Code	
(13) Proposed line of treatment: Investigation Intensive Care Medical Management Surgical Management Non allopathic treatment		
(14) If ' Investigation &/or Medical Management' provide detailed line of treatment with route of drug administration: -		
(15). a If Surgical, name of the Surgery along with PCS code & its details		(15). b ICD 10 PCS Code
(16) For other treatments, please furnish details:		
(17) A. How did injury occur		(17). C In case of MATERNITY G P L A LMP: - - / - - / - -
(17) B. In case of ACCIDENTS: Is it RTA Y / N Date of injury (DD (MM/YY): FIR / ML C Attached: Y / N Alcohol/Drug Intoxication Y / N if 'Y' sent the Analyzer Report		

18 (a) Probable Date & Time of Admission:		19. Past history of any chronic illness I f Yes, Duration Mandatory (Months /Year
18 (b) Is this an emergency/ a Planned Hospitalization Event?	Emergency: Y / N Planned: Y / N	19.01 Diabetes: Yes / No
18 © Expected no. Of days stay in Hosp		19.02 Heart Disease: Yes / No
18 (d) Room Type		19.03 Hypertension: Yes / No
18 (e) ICU charges		19.04 Hyperlipidemias: Yes / No
18 (f) Expected cost for Investigation + Diagnostics		19.05 Osteo Arthritis: Yes / No
18 (g) Per Day Room Rent + Nursing & Service Charges + Patient's Diet		19.06 Asthma/COPD/ Bronchitis: Yes / No
18 (h) OT charges		19.07 Cancer: Yes / No
18 (i) Professional fees Surgeon + Anesthetist Fees + consultation Charges		(20)a. Any h /o Alcohol abuse / intoxication? Y/ N
18 (j) Medicines + Consumables + Cost of Implants (If applicable please specify) Other Hospital expenses if any		(20)b. Any HIV or STD / Related ailments? Y / N
18 (k) All inclusive Package Charges if any applicable		(20)c.Any other Aliment: Yes / No If Yes Pls. give details
18 (l) SUM TOTAL EXPECTED COST OF HOSPITALIZATION Rs:		21. Any other relevant information:

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

Treating Doctor's Name & Signature	Hospital Seal	Patients/insurer's Name & Signature
Qualification and Registration Number		

HOSPITAL DECLARARTION

1. Hospital will be responsible for identifying and treating the right Insured patient & keep the TPA indemnified.
2. We have no objection to any authorized TPA/ Insurance Company official verifying documents pertaining to Hospitalization.
3. We will submit all original documents / Drug Prescriptions / Investigations / Reports, duly signed and sealed by the concerned Doctors/ Specialists in the specialty and not by the Technicians / countersigned by the insured / patient, to the TPA / Insurance Company, within 7 days of the patient's discharge, as per the checklist below .
4. 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.
5. 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 RELAVENT DOCUMENMTS.
6. The patient informed declaration has been signed by the patient or by his representative in our presence.
7. We agree to provide clarifications for the queries raised regarding this hospitalization within 14 days and we take the sole responsibility for any delay in offering clarifications.
8. We will abide by the terms and conditions agreed in the MOU

Doctor's Signature Hospital Seal

DECLARATION BY THE PATIENT / REPRESENTATIVE

1. I confirm under oath that I am the Insured person seeking Cashless / Reimbursement healthcare facility from the hospital and if found otherwise will accept the damages imposed.
2. 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.
3. Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer / TPA are not liable to settle the hospital bill; I take complete responsibility to settle the bill.
4. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer / I will pay T.P.A. In case any clarification is needed on admissibility of a particular item I shall contact T.P.A at the Toll Free Number on the reverse of this form.
5. I hereby declare to abide by the rules and regulations 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
6. I agree and understand that T.P.A is in no way warranting the service of the hospitals & that the Insurer/TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.
7. I hereby warrant the truth of the forgoing particulars in every respect and I agree than if I have made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that, in respect of the above treatment, no benefits are admissible under any other Medical Scheme or Insurance
8. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer/ TPA.

Patient's / Insured's Name_____ Patient's / Insured's Signature _____

Phone No:

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

1. Detailed Discharge Summary and all Bills from the hospital/ Pharmacy / Diagnostic Centers
2. Cash Memos from the Hospitals/ Chemists supported by proper prescription tabulated and signed by the Pharmacist.
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.

Corporate Office: # 48, 5th Main, Jayamahal Extension, Bangalore 560 046, Tel: 080 4099 3666 / 3777
Fax: 080 4283 5411, Email: **cashless@anyutatpa.com**, **Jaipur Office**: B 204, Amrut Kalash Building, Gopalpura, Tonk Road, Near Kamal & Co., Jaipur – 302 018,**Tel**: 0141 6596565, Fax: 0141 2700792, Email: **jaipurbo@anyutatpa.com**
Web: **www.anyutatpa.com**