Bajaj Allianz General Insurance Company Limited.
Regd. & Head Office : Bajaj Allianz House, Airport Road, Yerawada, Pune 411 006
CIN: U66010PN2000PLC015329

Caringly yours

BAJAJ Allianz

Health Administration Team : *A - Wing 2nd Floor, Bajaj Finserv Building, Behind Weikfield IT Park, Off Nagar Road, Viman Nagar | Pune - 411 014
Phone No.: 020-30305858/ 1800-103-2529 Fax: 020-30512224/ 6/ 7 | **Email:** preauth@bajajallianz.co.in

(To be filled in block letters)

CASHLESS FORM

PLEASE FAX/SCAN PAGE 1 AND 2 ONLY

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

SECTION A

DETAILS OF THE PROVIDER

Hospital Name/nursing Home Name:_____

_____

City Name:_____ Pin Code: | | | | | | | | | | | | | |

State Name:_____ Hosp Id: | | | | | | | | | | | | | |

Landmark:_____ Rohini ID | | | | | | | | | | | | | |

Hospital Contact No: _____ Fax No: _____ TPA desk No _____ Email id: _____

SECTION B

TO BE FILLED BY THE INSURED/PATIENT

a) Name of the Patient: _____

b) Current Address of Insured patient:_____

_____

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

f) Name of the Attendant:_____ g) Contact number, if any: | | | | | | | | | | |

h) Contact number: | | | | | | | | | | | i) Insured card ID number: | | | | | | | | | | | | | | | |

j) Occupation of Insured patient:_____ k) Policy number I Name of corporate:_____

l) Employee ID: | | | | | | | | | | | | | | | |

m) Currently do you have any other Mediclaim / Health insurance ☐ Yes ☐ No

Company Name:_____

Give details:_____

n) Do you have a family physician: ☐ Yes ☐ No o) Name of the family physician:_____

p)Contact number, if any: | | | | | | | | | | |

q) Insured E-mail id_____ **(PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THIS FORM)**

SECTION C

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 | Y | Y |

i. 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 & I 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: | D | D | | 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)

l) In case of Maternity: G ☐ P ☐ L ☐ A ☐ Expected date of Delivery: | D | D | | M | M | | Y | Y | Y | Y | LMP: | D | D | | M | M | | Y | Y | 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) Expected no.of days in ICU ☐☐☐ Days

g) Per Day Room Rent + Nursing & Service Charges + Patient's Diet: Rs. ☐☐☐☐☐☐☐

h) Expected cost for investigation + diagnostics.: Rs. ☐☐☐☐☐☐☐

i) ICU Charges: Rs. ☐☐☐☐☐☐☐

j) OT Charges: Rs. ☐☐☐☐☐☐☐

k) Professional fees Surgeon + Anesthetist Fees + consultation Charges: Rs. ☐☐☐☐☐☐☐

l) Medicines + Consumables + Cost of Implants specify). Other hospital expenses if any: Rs. ☐☐☐☐☐☐☐

m) All inclusive package charges if any applicable Rs. ☐☐☐☐☐☐☐

n) Sum Total expected cost of hospitalization Rs. ☐☐☐☐☐☐☐

Mandatory: Past History of any chronic illness (If yes, since (month / year)

- ☐ Diabetes ☐☐ ☐☐
- ☐ Heart Disease ☐☐ ☐☐
- ☐ Hypertension ☐☐ ☐☐
- ☐ Hyperlipidemia ☐☐ ☐☐
- ☐ Osteoarthritis ☐☐ ☐☐
- ☐ Asthma / COPD / Bronchitis ☐☐ ☐☐
- ☐ Cancer ☐☐ ☐☐
- ☐ Alcohol or drug abuse ☐☐ ☐☐
- ☐ Any HIV or STD / Related ailments ☐☐ ☐☐

Any other Ailment give details:_____

_____

_____

(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 3: NOT TO BE FAXED/SCANNED

DECLARATION BY THE PATIENT / REPRESENTATIVE

A. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Bajaj Allianz General Insurance Company Limited after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.

B. Payment to hospital is governed by the terms and conditions of the policy. In case the Bajaj Allianz General Insurance Company Limited is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.

C. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Bajaj Allianz General Insurance Company Limited not governed by the terms and conditions of the policy will be paid by me.

D . 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 Bajaj Allianz General Insurance Company Limited

E . I agree and understand that Bajaj Allianz General Insurance Company Limited is in no way warranting the service of the hospital & that the Bajaj Allianz General Insurance Company Limited is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.

F . 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.

G . I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Bajaj Allianz General Insurance Company Limited

I. I/We authorize Insurance Company/TPA to contact me/us through mobile/email for any update on this claim

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

b) Contact number: | | | | | | | | | | |

c) Patient's / Insured's Signature:

d) Email ID (optional)_____

Date - _____ Time - _____

HOSPITAL DECLARATION

1. We have no objection to any authorized Bajaj Allianz General Insurance Company Limited official verifying documents pertaining to hospitalization.
2. All valid original documents duty countersigned by the insured I patient as per the checklist below will be sent to Bajaj Allianz General Insurance Company Limited within 7 days of the patient's discharge.
3. WE AGREE THAT BAJAJ ALLIANZ GENERAL INSURANCE COMPANY LIMITED 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.
4. The patient declaration has been signed by the patient or by his representative in our presence.
5. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
6. We will abide by the terms and conditions agreed in the MOU.
7. We confirm that no additional amount would be collected liom the insured in excess of Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility choosing separate line of treatment which is not envisaged/considered in package).
8. We confirm that no recoveries would be made from the deposit amount collected from the insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package).
9. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA / Insurance Company reserves the right to recover the same from us (the Network Provider) and,/or take necessary action, as provided under the MOU or applicable laws

Hospital Seal

Doctor's Signature

Date-_____ Time - _____

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 I 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.

*As per IRDA circular Ref: IRDA/SDD/GDL/CIR/020/02/2013 Anti-Money Laundering /Counter Financing of Terrorism (AML/CFT)-Guidelines for General Insurers All general insurance companies are required to carry out KYC norms at the settlement stage where claim payout crosses a threshold of ` One lakh per claim. In cases where payments are made to third party service providers such as hospitals, the KYC norms shall apply on the customers on whose behalf service providers act.