Health ki Guarantee



Pre-Authorisation Form - 'Care' Request for Cashless Hospitalisation for Medical Insurance Policy

I. To be filled in CAPITAL LETTERS only.

2. If there is insufficient space, please provide further details on a separate sheet.

3. Please Fax/Scan Page I & 2 only.

Details of the Third Party Administrator

a)	Name of TPA/Insurance Company :						
b)	Toll Free Phone No.: C) Toll Free FAX : C <thc< th=""> C <thc< th=""></thc<></thc<>						
d)	Name of Hospital :						
	i) Address :						
	ii) Rohini ID :						
	iii) Email ID :						
Т	o be filled by the Insured/Patient						
a)	Name of the Patient :						
b)	Gender : M F Other c) Age : (YY) (YY) d) Date of Birth : / /						
	Contact Number : -						
ŕ	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						
	i) Company Name :						
	il) Give Details :						
k)	Do you have a family physician : Yes No						
I)	Name of the family physician :						
m)) Contact Number, if any :						
n)	Current Address of the Insured Patient :						
o)	Occupation of Insured Person :						
Т	o 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 :						
Ce	ra Haalth Insuranaa Limitad (Farmarky known as Dalisara Haalth Insuranaa Camnany Limitad)						

 Care Health Insurance Limited (Formerly known as Religare Health Insurance Company Limited)

 Registered Office: 5th Floor, 19 Chawla House, Nehru Place, New Delhi-110019
 Corresp. Office: Unit No. 604 - 607, 6th Floor, Tower C, Unitech Cyber Park, Sector-39, Gurugram-122001 (Haryana)

 Website: www.careinsurance.com
 E-mail: customerfirst@careinsurance.com
 Call us: 1800-102-4488 | 1800-102-6655

 CIN: U66000DL2007PLC161503
 UIN: RHIHLIP21017V052021
 IRDA Registration No. - 148

Non aliquatic treatment. b) If Gives of drug administration: i) Roue of drug administration: i) If Surgials, and of asgery: i) If Surgials, and of asgery: i) If Coll IPCS Code: j) If other treatments provide details : k) How did injury occur: j) If other treatments provide details : k) If asgerials, and of asgery: j) In case of accelers: k) Robert treatments provide details : k) In case of accelers: k) In case of accelers: k) Robert to Police: v) Inury/Disease caused due to substruct abus/Balchol communition: w) Inury/Disease cause due to substruct abus/Balchol communition: w) In case of Maesminy: G P L A Date of Delivery: y) Part Call condition: Masserine: w) Date o	g)	Proposed line of treatment : Medical Management Surgical Management Intensive care Investigation	
) Route of drug administration :) If Surgical name of surgery:) If CDI 0 PCS Code:) If other treatments provide details : (E) How did injury occur:) In case of accident i) Is 4 RTA: (E) No (I) Reported to Police : (I) In case of accident i) Is 4 RTA: (I) No (I) Pace of accident i) Is 4 RTA: (I) No (I) Pace of accident i) Is 4 RTA: (I) No (I) Pace of accident i) Is 4 RTA: (I) No (I) Pace of accident i) Is 4 RTA: (I) No (I) Pace of accident i) Is 4 RTA: (I) No (I) Pace of accident i) Is 4 RTA: (I) No (I) Pace of accident i) Is 4 RTA: (I) No (I) Pace of Collekery: (I) Pace of Delevery: (I) Pace of Delevery: (I) Pace of Admixton: (I) Pace of Admi		Non allopathic treatment	
i) If Surgical, name of surgery: j) ICD 10 PCS Code: j) ICD 10 PCS Code: j) If other treatments provide datals: k) Ico diriping occur: j) If cather treatments provide datals: k) Ieos diriping occur: j) In case of accident: j) Is that ICA: j) Yes: No ii) Reported to Police: j) Yes: No iii) Reported to Police: j) Yes: No iii) Reported to Police: j) Yes: No iii) Reported to establish this: If establish this: If establish this: iii: If establish this: If es	h)	If Investigation &/or Medical Management provide details :	
i) ICD IO PCS Code: j) If other treatments provide details: ii) In case of accident: iii) Reported to Police! iv) IngrytDisese caused due to substance abuselalcohol consumption: iv) IngrytDisese caused due to abuselalcohol consumption: iv) IngrytDisese caused due to substance abuselalcohol consumption: iv) IngrytDisese caused due to substance abuselalcohol consumption: iv) Diserced cost for Investigaton + Dagnostics iv) IngrytDisease ab		i) Route of drug administration :	
if other treatments provide details: if fother treatments provide details: k How did injury occur: ii) In case of accident: iii) Baported to Police: y iii) Reported to Police: Yes iii) Reported to Police: Yes No iii) Reported to Police: Yes No iv) Tots conducted to esubstance abuse/alcohol consumption: Yes No (If Yes attach reports) m) In case of Maternity: G P L A Date of Delivery: / / /	i)	If Surgical, name of surgery :	
k) How did injury occir : k) In case of accident: i) is it RTA: k) In case of accident: i) is it RTA: k) In case of accident: i) is it RTA: k) In case of accident: i) is it RTA: k) In case of accident: i) is it RTA: k) In case of Adrission: k) If it case of Matemity: c) G p) It case of Adrission: k) If it case k) If it c		i) ICD 10 PCS Code :	
1) In case of accident; i) is it RTA: Yes No ii) Date of injury: / / / / / / / / / / / / / / / / / / /	j)	If other treatments provide details :	
ii) Reported to Police: Yis No iv) FIR No: v) Injury/Disease caused due to substance abuse/alcohol consumption : Yes No w) Test conducted to establish this: Yes No (If Yes attach reports) m) In case of Maternity: G P L A Date of Admission : / / / / / / / / / / / / / / / / / / /	k)	How did injury occur :	
v) hjury/Disease caused due to substance abuse/alcohol consumption : Yes No vi) Test conducted to establish this : Yes No ((TYes attach reports) m) In case of Maternity : G P L A Date of Delivery : / / / / ((DDMMMYYYY)) Details of the patient admitted a) Date of Admission : / / / / ((DDMMMYYYY)) b) Time of Admission : : : : ((PHMMY)) c) Is this an emergency/a planned hospitalization event : Emergency Planned d) Expected no. of days stay in hospital : days e) Days in ICU : days f) Room Type : f) Per Day Room Rent + Nursing & Service Charges + Patient's Diet : Rs	I)	In case of accident: i) Is it RTA : Yes No ii) Date of injury : / / / (DD/MM/YYYY)	
w) Test conducted to establish this: Yes No (If Yes attach reports) m) In case of Maternity: G P L A Date of Delivery: / / / / () (DDMMMYYYY) Details of the patient admitted a) Date of Admission: / / / / () (DDMMMYYYY) b) Time of Admission: : : : ((PEHMM) c) Is this an emergency/a planned hospitalization event! Emergency/ Planned d) Expected no. of days stay in hospital: days e) Days in ICU: days f) Room Type: f) Per Day Room Rent + Nursing & Service Charges + Patient's Diet : Rs. I) g) Expected cost for Investigation + Diagnostics : Rs. IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII		iii) Reported to Police : Yes No iv) FIR No.:	
m) In case of Maternity: G P L A Date of Delivery: I I (DDMMMMMM) Details of the patient admitted a) Date of Admission: I I (DDMMMMMM) b) Time of Admission: I: (PH-MM) c) Is this an emergency/a planned hospitalization event? Emergency Planned Planned d) Expected no. of days stay in hospital: Image: Colspan="2">Genergency Planned g) Expected cost for lowestigation + Diagnostics Image: Colspan="2">Image: Colspan="2">Image: Colspan="2">Colspan="2" Colspan="2" Colspan=Colspan="2" </td <td></td> <td>v) Injury/Disease caused due to substance abuse/alcohol consumption : Yes No</td> <td></td>		v) Injury/Disease caused due to substance abuse/alcohol consumption : Yes No	
Details of the patient admitted a) Date of Admission: / / / () () Durft Marryny) b) Time of Admission: / / () () Is this an emergency/a planned hospitalization event? () Expected no. of days stay in hospital: () Expected no. of days stay in hospital: () Expected no. of days stay in hospital: () Expected cost for Investigation + Diagnostics () Expected cost for Investigation + Diagnostics () CU Charges () CU Charges () OT Charges () OT Charges () OT Charges () Professional Fees Surgeon + Anesthetist Fees + Consultation Charges () Professional Fees Surgeon + Anesthetist Fees + Consultation Charges () Other hospital Expenses: if any () Athronic Illness () Sum Total expected cost of hospitalization () Madatory: Past History of any chronic illness () Heart Disease () MHMMYN () Happertension () Mathronic Illness () Madatory: Past History of any chronic illness () Happertension () Mathread: () (MMMYN) () Happertension () Mathread: () (MMYN) () Athread: () (MMYN) <		vi) Test conducted to establish this : Yes No (If Yes attach reports)	
a) Date of Admission:	m)	In case of Maternity : G P L A Date of Delivery : / / / / (DD/MM	/YYYYY)
c) Is this an emergency/a planned hospitalization event!: Emergency Planned d) Expected no. of days stay in hospital:	De	etails of the patient admitted	
c) Expected no. of days stay in hospital :	a)	Date of Admission : / / (DD/MM/YYYY) b) Time of Admission : : (HH:MM)	
1) Per Day Room Rent + Nursing & Service Charges + Patient's Diet : Rs. g) Expected cost for Investigation + Diagnostics : Rs. g) Expected cost for Investigation + Diagnostics : Rs. h) ICU Charges : Rs. g) OT Charges : Rs. g) OT Charges : Rs. g) Professional Fees Surgeon + Anesthetist Fees + Consultation Charges : Rs. k) Medicines + Consumables + Cost of Implicable please specify). : Rs. g) Other hospital Expenses: if any : Rs. m) All inclusive package charges if any applicable : Rs. n) Sum Total expected cost of hospitalization : Rs. m) Sum Total expected cost of hospitalization : Rs. m) Sum Total expected cost of hospitalization : Rs. m) Diabetes :: (MHMYY) Heart Disease ::: (MHMYY) Hyperlipidemias ::: (MHMYY) Asthma/COPD/Bronchitis ::: (MHMYY) Actional or drug abuse :: (MHMYY) Alcohol or drug abuse :: (MHYYY) Alcohol or drug abuse :: (MHYYY) <td>c)</td> <td>Is this an emergency/a planned hospitalization event?: Emergency Planned</td> <td></td>	c)	Is this an emergency/a planned hospitalization event?: Emergency Planned	
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). : Rs. j) Other hospital Expenses: if any : Rs. m) All inclusive package charges if any applicable : Rs. n) Sum Total expected cost of hospitalization : Rs. Diabetes (MMMY) Heart Disease (MMMY) Hyperlipidemias (MMMY) Oscoarthritis (MMMY) Asthma/COPD/Bronchitis (MMMY) Acholo or drug abuse (MMYY) Alcohol or drug abuse (MMYY)	d)	Expected no. of days stay in hospital : days e) Days in ICU : days f) Room Type :	_
h) ICU Charges :Rs. i) OT Charges :Rs. j) Professional Fees Surgeon + Anesthetist Fees + Consultation Charges :Rs. j) Professional Fees Surgeon + Anesthetist Fees + Consultation Charges :Rs. k) Medicines + Consumables + Cost of Implants (if applicable please specify). :Rs. j) Other hospital Expenses: if any :Rs. m) All inclusive package charges if any applicable :Rs. n) Sum Total expected cost of hospitalization :Rs. m) All inclusive package charges if any applicable :Rs. m) Autory: Past History of any chronic illness Ifyes, since (month/year) in Diabetes (MMMYY) in Hypertension (MMYY) in Hypertipidemias (MMYYY) in Altonol or drug abuse (MMYYY) in Alcohol or drug abuse (MMYYY)	f)	Per Day Room Rent + Nursing & Service Charges + Patient's Diet : Rs.	
i) OT Charges : Rs. j) Professional Fees Surgeon + Anesthetist Fees + Consultation Charges : Rs. k) Medicines + Consumables + Cost of Implants (if applicable please specify). : Rs. j) Other hospital Expenses: if any : Rs. m) All inclusive package charges if any applicable : Rs. n) Sum Total expected cost of hospitalization : Rs. m) All inclusive package charges if any applicable : Rs. m) Sum Total expected cost of hospitalization : Rs. m) Sum Total expected cost of hospitalization : Rs. Diabetes : (MM/M) Heart Disease : (MM/M) Hypertension : (MM/M) Osteoarthritis : (MM/M) Gancer : (MM/M) Alcohol or drug abuse : (MM/M) Alcohol or drug abuse : (MM/M) AnyHIVor STD/Related ailments : (MM/M)	g)	Expected cost for Investigation + Diagnostics : Rs.	
i) Professional Fees Surgeon + Anesthetist Fees + Consultation Charges : Rs. i) Medicines + Consumables + Cost of Implants (if applicable please specify). : Rs. i) Other hospital Expenses: if any : Rs. m) All inclusive package charges if any applicable : Rs. n) Sum Total expected cost of hospitalization : Rs. Mendatory: Past History of any chronic illness If yes, since (month/year) j Diabetes (MMYY) j Heart Disease (MMYY) j Hyperlipidemias (MMYY) j Osteoarthritis (MMYY) j Asthma/COPD/Bronchitis (MMYY) j Alcohol or drug abuse (MMYY) j Alcohol or drug abuse (MMYY) j Any HIV or STD / Related aliments (MMYY)	h)	ICU Charges : Rs.	
k) Medicines + Consumables + Cost of Implants (if applicable please specify). : Rs. i) Other hospital Expenses: if any : Rs. m) All inclusive package charges if any applicable : Rs. m) All inclusive package charges if any applicable : Rs. m) Sum Total expected cost of hospitalization : Rs. m) Sum Total expected cost of hospitalization : Rs. m) Diabetes (MMMYY) heart Disease (MMMYY) Hyperlipidemias (MMMYY) Osteoarthritis (MMMYY) Asthma/COPD/Bronchitis (MMMYY) Alcohol or drug abuse (MMYY) Alcohol or drug abuse (MMYY)	i)	OT Charges : Rs.	
i) 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 (MM/YY) Heart Disease (MM/YY) Hypertension (MM/YY) Hypertipidemias (MM/YY) Osteoarthritis (MM/YY) Osteoarthritis (MM/YY) Asthma/COPD/Bronchitis (MM/YY) Actohol or drug abuse (MM/YY) Any HIV or STD / Related ailments (MM/YY)	j)	Professional Fees Surgeon + Anesthetist Fees + Consultation Charges : 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 (MM/YY) Heart Disease (MM/YY) Hypertension (MM/YY) Hypertipidemias (MM/YY) Osteoarthritis (MM/YY) Osteoarthritis (MM/YY) Asthma/COPD/Bronchitis (MM/YY) Actohol or drug abuse (MM/YY) Any HIV or STD / Related ailments (MM/YY)	k)	Medicines + Consumables + Cost of Implants (if applicable please specify).	
n) Sum Total expected cost of hospitalization Mandatory: Past History of any chronic illness Diabetes Heart Disease Hypertension Hyperlipidemias Osteoarthritis Osteoarthritis Asthma/COPD/Bronchitis Cancer Atchol or drug abuse Any HIV or STD / Related ailments	I)	Other hospital Expenses: if any : Rs.	
Mandatory: Past History of any chronic illness If yes, since (month/year) Diabetes (MM/YY) Heart Disease (MM/YY) Hypertension (MM/YY) Hyperlipidemias (MM/YY) Osteoarthritis (MM/YY) Asthma/COPD/Bronchitis (MM/YY) Cancer (MM/YY) Alcohol or drug abuse (MM/YY) Any HIV or STD / Related ailments (MM/YY)	m)	All inclusive package charges if any applicable : Rs.	
Diabetes Heart Disease Hypertension Hyperlipidemias Osteoarthritis Osteoarthritis Asthma/COPD/Bronchitis Cancer Achol or drug abuse Any HIV or STD / Related ailments	n)	Sum Total expected cost of hospitalization : Rs.	
Heart Disease Hypertension Hyperlipidemias Osteoarthritis Osteoarthritis Asthma/COPD/Bronchitis Cancer Alcohol or drug abuse Any HIV or STD / Related ailments	Ma	andatory: Past History of any chronic illness If yes, since (month/year)	
Hypertension Hyperlipidemias Osteoarthritis Asthma/COPD/Bronchitis Cancer Alcohol or drug abuse Alcohol or drug abuse Any HIV or STD / Related ailments		Diabetes (MM/YY)	
Hyperlipidemias Osteoarthritis Asthma/COPD/Bronchitis Cancer Alcohol or drug abuse Any HIV or STD / Related ailments		Heart Disease (MM/YY)	
Osteoarthritis Asthma/COPD/Bronchitis Cancer Alcohol or drug abuse Any HIV or STD / Related ailments		Hypertension (MM/YY)	
Asthma/COPD/Bronchitis Cancer Alcohol or drug abuse Any HIV or STD / Related ailments		Hyperlipidemias (MM/YY)	
Cancer (MM/YY) Alcohol or drug abuse (MM/YY) Any HIV or STD / Related ailments (MM/YY)		Osteoarthritis (MM/YY)	
Alcohol or drug abuse (MM/YY) Any HIV or STD / Related ailments (MM/YY)		Asthma/COPD/Bronchitis (MM/YY)	
Any HIV or STD / Related ailments			

Care Health Insurance Limited (Formerly known as Religare Health Insurance Company Limited) Registered Office: 5th Floor, 19 Chawla House, Nehru Place, New Delhi-110019 Corresp. Office: Unit No. 604 - 607, 6th Floor, Tower C, Unitech Cyber Park, Sector-39, Gurugram-122001 (Haryana) Website: www.careinsurance.com E-mail: customerfirst@careinsurance.com Call us: 1800-102-4488 | 1800-102-6655 CIN: U66000DL2007PLC161503 UIN: RHIHLIP21017V052021 IRDA Registration No. - 148 Page 2

Declaration

We confirm having read understood and agreed to the Declarations on the next page of this form.				(Please read very carefully)		
a) N	Name of the treating doctor :					
b) (Qualification:					
c) F	Registration No. with State Code:					
ŀ	Hospital Seal (Must include Hospital ID) Patient/Insured	d Name &	Signature			
Declaration by the Patient/Representative Not to be Faxed or Scanned						
a. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/TPA after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.						
	ayment to hospital is governed by the terms and conditions of the policy. In case the Insurer/TPA is not liable to settle the hospital ill as per the terms and conditions of the policy.	bill, l unde	ertake to se	ettle the		

- All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/TPA 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 Insurer/TPA.
- e. I agree and understand that TPA 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.
- 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 indemnifo the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer/TPA.
- h. 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) Email ID (optional):	
d) Patient's/Insured's Signature :	Date :	Time :	

Hospital Declaration

- a. We have no objection to any authorized TPA/Insurance Company official verifying documents pertaining to hospitalization.
- b. 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.
- c. 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.
- d. The patient declaration has been signed by the patient or by his representative in our presence.
- e. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
- f. We will abide by the terms and conditions agreed in the MOU.
- g. We confirm that no additional amount would be collected from 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).
- h. 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).
- i. 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 : _____