CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED
Claims Processing Centre: Shaw Wallace Building, New No. 319, Old No.154, 2nd Floor, Thambu Chetty Street, Parrys, Chennai- 600001
Toll Free Ph No.: 1800 200 5544, Toll Free Fax No.: 1800 425 2200
Pre Authorization Request: faxhealth@cholams.murugappa.com;
Queries & Complaints: customercare@cholams.murugappa.com
www.cholainsurance.com

PLEASE FAX / SCAN PAGE 1 ONLY

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

DETAILS OF THE THIRD PARTY ADMINISTRATOR

(To be filled in block letters)

a) Name of TPA / Insurance company:

b) Toll free phone number:

c) Toll free FAX:

TO BE FILLED BY THE INSURED / PATIENT

a) Name of the Patient:

b) Gender: ☐ Male ☐ Female c) Age: Years [Y][Y] Months [M][M] d) Contact Number Contact Number of attending Relative

e) Insured card ID number: f) Policy number / Corporate:

g) Employee ID: h) Currently do you have any other Mediclaim / Health insurance: ☐ Yes ☐ No

i. Company Name ii. Give details:

iii. Policy No. iv. Sum Insured c) Aadhaar Enrollment No. / :

i) Name of the family physician: j) Contact number:

k) PAN: l) Aadhaar No.:

m) Aadhaar Enrollment No.:

Note : PAN & Aadhaar No. Mandatory for as per IRDAI. If applied for Aadhaar, kindly provide Enrolment ID
In case of Non availability of PAN CARD – FORM 60 as per the annexure need to be provided.

(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 l) Date of first consultation: [D][D] [M][M] [Y][Y] ll) Past history of present ailment if any:

f) Provisional diagnosis:

l) 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 :

l) ICD 10 PCS Code:

j) If other treatments provide details:

k) How did injury occur:

l) In case of accident: ll) Is it RTA: ☐ Yes ☐ No lll) Date of injury: [D][D] [M][M] [Y][Y] iv) Reported to Police: ☐ Yes ☐ No 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 LMP [D][D] [M][M] [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) Per Day Room Rent + Nursing & Service Charges + Patient's Diet: Rs.

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) . Other hospital expenses if any: Rs.

l) All inclusive package charges if any applicable Rs.

m) **Sum Total expected cost of hospitalization** **Rs.**

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

☐ Diabetes	[M][M]	[Y][Y]
☐ Heart Disease	[M][M]	[Y][Y]
☐ Hypertension	[M][M]	[Y][Y]
☐ Hyperlipidemias	[M][M]	[Y][Y]
☐ Osteoarthritis	[M][M]	[Y][Y]
☐ Asthma / COPD / Bronchitis	[M][M]	[Y][Y]
☐ Cancer	[M][M]	[Y][Y]
☐ Alcohol or drug abuse	[M][M]	[Y][Y]
☐ Any HIV or STD / Related ailments	[M][M]	[Y][Y]

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: [S][U][R][N][A][M][E] [F][I][R][S][T] [N][A][M][E] [M][I][D][D][L][E] [N][A][M][E]

b) Qualification: c) Registration No. with State Code:

Signature of treating doctor

Hospital Seal (Must include Hospital ID)

Patient / Insured Name & Signature:

Note : Please enclose a cancelled cheque / copy of the same, NEFT cannot be facilitated without the cancelled cheque / copy

(IMPORTANT: PLEASE TURN OVER)

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 settlethe 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 thelimit authorized by the Insurer/T.P.A not governed by the terms and conditions of the policy will be paid by me. 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.
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 tobe 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, 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
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:** _____ d) **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-authorisation 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 responsibilityfor 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.
6. Original Final Bills has to be signed by the Patient / Insured.

DOCUMENTS TO BE PROVIDED BY THE PATIENT / INSURED IN SUPPORT OF THE CLAIM

1. Aadhar card copy.
2. Pan card copy.
3. In case of Non availability of PAN CARD – FORM 60 as per the annexure need to be provided.

Income-tax Rules, 1962

FORM NO. 60

[See second proviso to rule 114B]

Form for declaration to be filed by an individual or a person (not being a company or firm) who does not have a permanent account number and who enters into any transaction specified in rule 114B

First Name :	
Middle Name :	
Surname :	
Date of Birth / Incorporation of declarant :	D D M M Y Y Y Y
Father's Name (in case of individual) :	
First Name :	
Middle Name :	
Surname :	
Flat/ Room No. :	Floor No. :
Name of premises :	Block Name/No. :
Road/ Street/ Lane	Area/ Locality
Town/ City	District
State	Pin code
Telephone Number (with STD code)	Mobile Number
Amount of transaction (Rs.)	
Date of transaction	D D M M Y Y Y Y
In case of transaction in joint names, number of persons involved in the transaction	
Mode of transaction: ☐ Cash, ☐ Cheque, ☐ Card, ☐ Draft/Banker's Cheque, ☐ Online transfer, ☐ Other	
Aadhaar Number issued by UIDAI (if available)	
If applied for PAN and it is not yet generated enter date of application and acknowledgement number	D D M M Y Y Y Y
If PAN not applied, fill estimated total income (including income of spouse, minor child etc. as per section 64 of Income-tax Act, 1961) for the financial year in which the above transaction is held	
a. Agricultural income (Rs.)	
b. Other than agricultural income (Rs.)	

Details of document being produced in support of identify in Column 1 *(Refer Instruction overleaf)*	Document code	Document identification number	Name and address of the authority issuing the document
Details of document being produced in support of address in Columns 4 to 13 *(Refer Instruction overleaf)*	Document code	Document identification number	Name and address of the authority issuing the document

Verification

I, _____ do hereby declare that whatis stated above is true to the best of my knowledge and belief. I further declare that I do not have a Permanent Account Number and my/ our estimated total income (including income of spouse, minor child etc. as per section 64 of Income-tax Act, 1961) computed in accordance with the provisions of Income-tax Act, 1961 for the financial year in which the above transaction is held will be less than maximum amount not chargeable to tax.

Verified today, the _____ day of _____ 20_____

Place: _____ (Signature of declarant)