PLEASE FAX / SCAN PAGE 1 ONLY

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

Name of the Hospital

Hospital Location | Hospital ID

Hospital Fax No. | Hospital Phone No

DETAILS OF THIRD PARTY ADMINISTRATOR (To be filled in block letter)

a) Name of TPA / Insurance Company: **Ericson Insurance TPA Pvt. Ltd.**

b) Toll Free Phone Number: **1800222034**

c) Toll Free Fax: 022-25270200

TO BE FILLED BY THE INSURED / PATIENT

a) Name of the Patient: SURNAME FIRST NAME MIDDLE NAME

b) Gender: Male Female c) Age: Years (YY) Months (MM) d) Date of birth (DD MM YYYY)

e) Contact number: f) Insured Card ID Number:

g) Policy number / Name of corporate: h) Employee ID:

h) Currently do you have any other Mediclaim / Health Insurance: Yes No Company Name

Give details:

i) Do you have a family physician Yes No j) Name of the family physician

k) 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) Name of ILLNESS / Disease with presenting complaints

d) Relevant clinical findings:

e) Duration of the present ailment: Days f) Date of first consultation (DD MM YY)

ii. Past history of present ailment if any:

f) Provisional diagnosis:

iii. ICD 10 Code:

g) Proposed line of treatment: Medical Management Surgical Management Intensive care Investigation Non allopathic treatment

h) If investigation & / or Medical Management provides 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: (MM YY YY) 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)

m) In case of Maternity: G P L A Date of Delivery: (DD MM YY)

Details of the patient admitted

a) Date of admission: (DD MM YY) b) Time (HH MM)

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	(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)

Any other Ailment give details:

(PLEASE READ VERY CAREFULLY)

DECLARATION

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

a) Name of the treating doctor: SURNAME FIRST NAME MIDDLE NAME

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

Hospital Seal (Must include Hospital ID)

Patient / Insured Name & Signature:

(IMPORTANT: PLEASE TURN OVER)

DECLARATION BY THE PATIENT / REPRESENTATIVE

1. 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.
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 amount 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 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 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 pertaing to hospitalization
2. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent TPA / Insurance Company within 7 days of the patient's discharge.
2. 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 represent in our presence.
6. We agree provide clarification 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.